

MEMORANDUM

Texas Department of Human Services * Long Term Care/Policy

TO: LTC-R Regional Directors
Section/Unit Managers

FROM: Marc Gold
Section Manager
Long Term Care-Policy
State Office MC: W-519

SUBJECT: Regional Survey & Certification Letter #98-17

DATE: September 15, 1998

The attached RS&C Letter is being provided to you for information purposes and should be shared with all professional staff.

- RS&C Letter No. 98-17--Clarification of Survey Issues; Call Carol Ahmed, Education Services Section Manager, (512) 438-2867.

If you have any questions, please direct inquiries to the individuals or sections listed above.

~Original Signature on File~

Marc Gold

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Region VI
1301 Young Street, Room 833
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August 31, 1998

REGIONAL SURVEY AND CERTIFICATION LETTER NO: 98-17

To: All State Survey Agencies

Subject: Clarification of Survey Issues

The purpose of this letter is to share information about a composite of conclusions discussed by a review team workgroup over the past year, and training provided since the implementation of the 1995 Long Term Care (LTC) survey process and enforcement regulation. This information is not new, but represents a compilation of previously presented guidance.

As part of the implementation of the revised LTC survey process and enforcement regulation, a national review team was formed to conduct reviews of Statement of Deficiencies. This group first met in July of 1996 and consisted of surveyors and survey supervisory staff from all ten HCFA Regional Offices and Central Office. This memo is a beginning effort to clarify on-going survey process issues.

Each office reviewed a random selection of deficiencies. The group discussed these via monthly teleconferences over a period of five months. After meeting and discussing these deficiencies, the same issues continued to come up regarding the information gathering and decision-making processes of the LTC survey. The group decided that persisting in reviewing Statements of Deficiencies would not be productive.

One main difficulty was that not all surveyors and offices had access to the same information sent out or discussed at various training sessions or conferences. To resolve this situation, I am sending the previously presented document, "LTC Survey Guidance - Information Gathering" for review.

If you have any questions concerning the information, please contact Pat Brown at (214) 767-4416.

Sincerely,

{Signature on File}

Theresa E. Bennett for
Molly Crawshaw, Acting Chief
Survey and Certification Operations Branch
Division of Medicaid and State Operations

Enclosures

LTC Survey Guidance - Information Gathering

Avoidable or Unavoidable

When a decline has occurred or there are indications that the resident has not reached his/her highest practicable level, gather detailed information. It is not sufficient to only gather information indicating the decline or failure to reach the highest practicable level occurred. Rather, it is necessary to determine if this outcome was avoidable or unavoidable by conducting: multiple observations; ongoing dialogue with the direct care-giving staff, resident, and family; and targeted record review to clarify and validate information.

Determine if the facility:

- Has a continuous ongoing process for consistently providing individualized care and services for the resident. This information is obtained by on-going observations and dialogue with residents, family and staff;
- Completes a comprehensive, appropriate, and adequate assessment of the resident which identifies the resident's baseline status and potential for improvement;
- Identifies and assesses risk factors that were/are present for this particular resident and that may have contributed to the decline or failure to improve, including natural progression of the medical conditions;
- Develops appropriate care plans and consistently implements those appropriate care plan interventions to forestall disease progression and to address risks, needs, and strengths; and
- Conducts on-going evaluation of the outcomes of the care: does the facility determine if the resident reached his/her goals, declined, or improved. If there was decline or no improvement, are alternate care and service interventions tried and adapted as needed for the resident.

The avoidability of decline and failure to improve is evaluated against the backdrop of the assessment, interventions, the resident's individual baseline functional status, and the natural history of the disease states. Neither surveyors nor providers should assume that age, chronic disease, etc., inevitably result in a resident's decline or failure to maintain the level of functioning so that such an outcome is always unavoidable. The possibility and opportunity for positive response or outcomes to appropriate interventions should always be provided.

If any of the following are found, then the decline was likely **avoidable**:

- Assessments are incomplete, and/or not accurate and not conducted in an on-going, individualized, comprehensive manner;
- Interventions are not on-going, or completely implemented, or provided according to accepted standards of care, also;
- There is not an on-going process of evaluating the resident's response and outcomes to the care and services being provided, and reassessment and revision of interventions is not done in response to the resident's response and outcomes (unless all reasonable options have been aggressively attempted and exhausted).

Decline is likely **unavoidable** when one or more of the following is present:

- Progression of the underlying disease, aging and/or other factors contribute to the decline **and** all possible appropriate interventions have been aggressively implemented but have not changed the course of decline. This includes that all probable contributors to potential decline such as medical conditions, psychosocial factors, activity level, medications, treatments, etc. have been identified, comprehensively assessed, and addressed through care-planning, continuous implementation of interventions, and evaluation of responses to interventions with other/alternate interventions tried; and/or
- There is a steadfast refusal of care despite on-going efforts to counsel the resident and offer alternative treatments.

Highest Practicable

To assist the resident to reach his/her highest practicable level of functioning, the facility must determine the level of normal effects of aging and the progression of the resident's disease process. To counteract, reduce, or retard, to the extent possible, the normal effects of aging or continuing disease processes, the facility should take into consideration the nature of the individual's clinical status, implement interventions consistent with the best practices of care, and the individual resident's strengths and potential for improvement or maintenance.

Once the facility has identified the resident's baseline level of functioning through the comprehensive individualized assessment, the potential causes of the resident's problems, individual resident strengths, and potential for improvement or maintenance, the facility must integrate the available information. From this information, the facility must develop meaningful and measurable resident specific objectives (or goals) and implement interventions to assist the resident to achieve or maintain his/her highest practicable level of functioning. Facility approaches to care should be based upon recognized standards of care for the population being served in the facility and should be modified as the resident's condition changes.

When a resident has failed to maintain, attain, or make progress toward reaching his/her highest practicable level of well-being, gather information to determine whether the facility has consistently implemented all interventions to assist the resident to reach his/her highest practicable level of physical, mental, and psychosocial functioning.

Determine if the facility:

- When conducting the assessment, captured the total picture of the resident, including the resident's functional capabilities, behaviors, and assistance needed throughout a 24 hour day period;
- Made observations at various times when the resident could demonstrate his/her functional ability and at times when he/she would need maximum assistance, ask the staff how they collected this information;
- Consistently implemented a comprehensive care plan with short and long-term objectives and interventions designed to help the resident achieve his/her goals. The process of problem identification when integrated with sound clinical interventions, reliable care planning, implementation of interventions, and evaluation of outcomes and responses becomes each resident's unique path toward achieving or maintaining his or her highest practicable level of well-being. The long and short-term objectives (goals) should describe whether improvement or maintenance is expected; and
- Provided optimal opportunities to residents during functional activities? Compare the observed functional capability of the resident to the comprehensive assessment. Conduct on-going informal dialogue with staff and residents as needed regarding the assessment process and any existing discrepancies, and find out the rationale/reasons for the discrepancies.

In summary, evaluate whether the facility has: identified the resident's need/problem/ability to improve or maintain his/her level of functioning ; planned care to address their need(s); implemented the interventions targeted toward achieving his/her highest practicable level; and modified the care if the resident achieved his/her objective or if there was no progress. The survey evaluates whether the facility has met the regulations to do this; i.e., provided all aspects of the care and services outlined above to assist the resident to reach his/her "highest practicable level of functioning."

Investigating Restraint Use

While Federal regulations and the Social Security Act do not ban the use of restraints, Federal requirements prohibit their use except in certain circumstances; i.e., when they are determined to be necessary to treat an individual's medical symptoms. Medical symptoms are the manifestations of illness that include both the subjective complaints that individuals bring to their care givers, as well as the objective data elicited by an examiner.

The overwhelming evidence is that restraint use contributes to a downward spiral of deterioration in the overall condition of nursing home residents. Therefore, the decision to apply a restraint of any kind must be made very

cautiously only: within the framework of the resident's individualized comprehensive assessment of his/her strengths and weaknesses; after weighing the risks and benefits to the resident of all possible interventions to address the medical symptoms; and only when the facility has exhausted other reasonable approaches and alternatives. The assessment must indicate the specific need and circumstances requiring the restraint use and must identify what interventions the facility will implement to minimize the psychological or physical risk to the resident or to reduce the use of restraints. Among the negative effects of restraint use, are the following:

- Physical risks such as bed sores, infection, reduced circulation, muscle atrophy, falls, pneumonia, loss of appetite, constipation, and incontinence are precipitated by immobility.
- Psychological risks involved with restraint use include humiliation, fear of being abandoned, impaired self-image, depression, agitation, catastrophic reactions for residents with dementia, panic, acting out behaviors, and disorientation.

It is important to note that medical symptoms alone do not justify the use of a restraint. Identification of the symptoms must be accompanied by a comprehensive assessment undertaken to determine the best intervention for treating those symptoms; that is, one which promotes the individual's attainment of their highest practicable level of functioning. There are no medical symptoms that automatically trigger the use of restraints.

To determine compliance with the restraint regulation, it is critical to understand that restraint use encompasses restrictive practices and behaviors as well as the application of restrictive devices. Another key element is an understanding whether the particular restraint or practice is known to effectively treat the presenting symptom either by improving the condition which caused the symptom or by preventing worsening of the condition.

TOUR:

Being observations during the tour. Document the type(s) of restraint(s) observed, the name(s) and location(s) of the resident(s) involved, the types of activities the resident is involved in, and the actions/reactions of staff to residents in the area. Look around the residents' rooms for devices left on dressers, night tables, radiators, chairs, etc.

Ask staff accompanying you on the tour why the restraint is being used. The response should reflect the individual circumstances and/or symptoms for why the restraint is being used.

If the resident is interviewable or the family is available, ask the resident or family questions about the restraint such as:

- Why do you have bed rails, seat belt, tray table?;
- What has the staff told you about (device name)?; and/or
- Can you release the restraint? (Have the staff ask him/her to release the restraint.)

If the staff convinced the resident or family that the device is necessary, corroborate this information throughout the survey. Whenever responses such as safety, control of behavior or wandering, or family request are elicited from either staff or residents as rationale for use of the restraint, be alert to possible systemic restraint problems.

SAMPLING:

Share the findings at the Phase I sampling meeting so the team can discuss the existence and potential extent of the concern within this facility. Because the initial observations from the tour do not provide adequate information to determine if the facility is in compliance with the requirements, once the use of restraints has been noted, the sample should include residents who are restrained.

RESIDENT REVIEW:

OBSERVE the resident and the care giver(s) and monitor them over a period of time to determine:

- The functional and cognitive status of the resident;
- When the restraint is being used, precipitating events, other alternatives tried before the application of the restraint, and the resident's response to its use;
- Whether the restraint is being applied in accord with manufacturer specifications and released or removed periodically based on individual needs or when staff or family was present; e.g., meals, activities, visits;
- Whether the resident has been repositioned;
- The resident's position when the restraint device is on both during initial application and throughout the period of use (e.g., was the resident in bed or wheelchair, ambulating, or in a Merry Walker). Was the device effective in maintaining the desired position (if the restraint was for positioning?); and
- If the device was removed, what did the staff do with the resident (ambulate, toilet, engage in an activity with the resident), and how the resident did respond to the restraint being off.

NOTE: When a restraint is applied for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, this pertains to the restraint regulation at 42 CFR 48.13(a). For problems with restraint application, repositioning, and period removal, these are also care issues to be investigated pertaining to 42 CFR 483.25.

Make several observations of the resident before questioning the staff.

INTERVIEW STAFF with follow up questions and have staff verify their answers with documentation from the resident's chart and other appropriate facility records.

- What is the purpose for the restraint being used?
- What conditions are causing the types of symptoms you discovered while you were investigating the necessity of restraint use?
- What non-restrictive measures has the facility used to address these conditions and symptoms and what was the result?
- How did you decide that this or other devices/measures/methods were not working?
- Upon what current standards of practice are you basing your use of this restraint?
- How is this restraint helping the resident achieve his/her highest level of function?
- What are the parameters for use of the restraint. How is the use of the restraint(s) being monitored/re-evaluated?
- What is your plan to reduce restraint use for this resident?
- If it is not possible to reduce the use of the restraint, explain why and what other resident-specific program is in place to help reduce the use of restraints.
- If the device is used for positioning, were physical or occupational therapy involved in the assessment, the determination of what mechanism was best, and other needed ongoing interventions?
- What information about restraint use is given to the resident and/or family at admission and care planning for the use of a restraint?

RECORD REVIEW:

If restraint use is prevalent in the facility surveyors should take note if all the MD orders reviewed say similar things such as "(device name) used for safety" or "prevention of falls" or "positioning to allow freedom to move wheelchair about." This may indicate that the facility has house orders for restraints, and a possible lack of assessment for the use. If the resident is newly admitted, check the reason for the restraint. Note whether restraints were present on admission to the facility. Are restraints being ordered on admission without having an adequate assessment?

When there are remaining questions concerning the information that has been obtained from observations and interviews with the staff and resident/family, target the record review to obtain the answers necessary to determine compliance. The surveyor should review the MDS for areas affected by restraint use as well as whether the facility

utilized information from the RAP for restraints and other related Raps in making the decision to sue a restraint. The review of Activities of daily living such as ambulation, bed mobility, and transfer are important in determine if the device meets the definition of a restraint. It is also important to review these sections over time to determine if improvement/decline resulted form the use of the restraints. If the RAI does not address and comprehensively assess for the use of restraints, determine if the restraints were implemented after the last annual or significant change assessment. Talk with the staff to determine how the facility arrived at the decision that utilization of restraints was not a significant change or that no comprehensive assessment was necessary.

The surveyor should be able to determine from staff interviews and verify and clarify by the record:

- What symptom is being treated and its causative factors;
- Whether there is concomitant use of psychoactive medications;
- Whether and how frequently staff considered and attempted any non-restrictive measures/devices/methods to assist the resident with the problem. If other measures were attempted, what happened?;
- If other measures were tried, what prompted the move to using the current restraint;
- What other methods are being implemented to address the symptoms (such as strengthening exercises). When utilized, did the therapists perform an objective evaluation of the resident condition and needs?;
- Whether the care plan indicates how staff plan to reduce the use of the device as the symptoms lessen; and
- How the facility will determine whether the symptoms are lessening.

As with any survey activity, document locations, dates, times and circumstances surrounding information obtained from observations, records, and staff and residents.