

# Nursing Facility Quality Review 2008

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Texas Department of Aging and Disability Services  
Center for Policy and Innovation  
Quality Assurance and Improvement









# **2008 Nursing Facility Quality Review**

## **A Statewide Assessment of Quality of Care and Quality of Life for Residents of Texas Medicaid-Certified Nursing Facilities**



**Prepared by**

**Elyse L. Luke, MSPH  
Program Specialist**

**Texas Department of Aging and Disability Services  
Center for Policy and Innovation  
Quality Assurance and Improvement  
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## Table of Contents

<b>Preface.....</b>	<b>vi</b>
<b>1.0 Executive Summary .....</b>	<b>1</b>
1.1 Quality of Care and Quality of Life Key Findings .....	1
<b>2.0 Methods.....</b>	<b>2</b>
2.1 The 2008 Nursing Facility Quality Review Instrument.....	2
2.2 Sampling .....	2
2.3 Data Collection .....	3
2.4 Data Analysis.....	3
<b>3.0 Findings.....</b>	<b>4</b>
3.1 Demographics .....	4
3.2 Urinary Incontinence .....	6
3.3 Pressure Ulcers.....	10
3.4 Infectious Illnesses.....	15
3.5 Pain Assessment and Pain Control .....	19
3.6 Fall Risk Management Practices.....	23
3.7 Immunization Practices.....	27
3.8 Advance Care Planning.....	31
3.9 Artificial Nutrition and Hydration .....	35
3.10 Nutrition, Unintended Weight Loss, and Hydration .....	39
3.11 Medication Practice and Safety .....	42
3.11.1 Prescribed Medicines.....	42
3.11.2 Potential for Drug Interactions and the Top 10 List .....	43
3.11.3 Beers List .....	44
3.12 Psychoactive Medication Usage .....	45
3.12.1 Antipsychotic Medications .....	45
3.12.2 Anti-Anxiety Medications .....	49
3.12.3 Sedative/Hypnotic (Sleep) Medications .....	50
3.13 Restraints.....	53
3.14 Quality of Life/Consumer Satisfaction .....	57
<b>4.0 DADS Initiatives and Collaborative Efforts.....</b>	<b>68</b>
<b>5.0 Conclusion .....</b>	<b>72</b>
<b>6.0 References.....</b>	<b>73</b>



<b>Appendix A – 2008 Nursing Facility Quality Review Survey .....</b>	<b>77</b>
Part 1. Identifying Information .....	77
Part 2. Assessment of Urinary Continence .....	78
Part 3. Pressure Ulcers .....	79
Part 4. Infectious Illnesses .....	80
Part 5. Pain Assessment .....	81
Part 6. Fall Risk Assessment.....	82
Part 7. Immunizations .....	83
Part 8. Advance Care Planning .....	84
Part 9. Tube Feeding.....	85
Part 10. Nutrition .....	86
Part 11. Use of Anti-anxiety Medications.....	86
Part 12. Use of Hypnotic Medications.....	87
Part 13. Restraints .....	88
Part 14. Quality of Life / Consumer Satisfaction.....	89
 <b>Appendix B – Acronyms.....</b>	 <b>93</b>

### **Table of Figures**

Figure 3.2 Urinary Incontinence .....	9
Figure 3.3 Pressure Ulcers .....	13
Figure 3.4 Infectious Illnesses .....	17
Figure 3.5 Pain Assessment and Control .....	21
Figure 3.6 Fall Risk Management.....	25
Figure 3.7 Immunizations .....	29
Figure 3.8 Advance Care Planning .....	33
Figure 3.9 Artificial Nutrition & Hydration .....	37
Figure 3.10 Nutrition, Unintended Weight Loss & Hydration .....	41
Figure 3.11 Medication Practice & Safety.....	47
Figure 3.12 Psychoactive Medications .....	51
Figure 3.13 Restraints .....	55
Figure 3.14 Quality of Life - Overall Quality of Life.....	59
Figure 3.14a Quality of Life - Dining Experience.....	63
Figure 3.14b Quality of Life - Activities .....	63
Figure 3.14c Quality of Life - Socialization & Privacy.....	65
Figure 3.14d Quality of Life – Safety & Possessions.....	65
Figure 3.14e Quality of Life – Safety & Security.....	67
Figure 3.14f Quality of Life – Ombudsman .....	67

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## **Preface**

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### **Approach to Assessing the Quality of Texas Nursing Facilities**

State law directs the Texas Department of Aging and Disability Services (DADS) to conduct surveys of residents in nursing facilities to assess how satisfied they are with their quality of care and quality of life and to perform on-site case reviews. DADS contracted with the Nurse Aide Competency Evaluation Service Plus Foundation, Inc. (hereafter referred to as NACES) to perform on-site assessments and surveys of residents in nursing facilities.

The Nursing Facility Quality Review (NFQR) includes a valid random sample of individuals across the state living in nursing facilities that were assessed and interviewed. Analysis of the NFQR data allows DADS to assess resident quality of care and quality of life and formulate strategies throughout DADS programs to continuously improve outcomes for individuals who reside in nursing facilities.

## **1.0 Executive Summary**

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The NFQR is a statewide process used by DADS to benchmark the quality of care and the quality of life for individuals in nursing facilities across the state. NFQR data collected over time helps DADS track progress in quality improvement activities and formulate strategies which are meant to improve both the quality of long-term services and supports and clinical outcomes of residents.

This year, of the 128,971 residents (including those with Medicare, Medicaid, or any other payer source) living in the 1,044 Medicaid certified nursing facilities in Texas at any time during a four month period, a subset of 2,129 residents were randomly selected, assessed, and interviewed. Key findings from this year's evaluation are noted below.

### **1.1 Quality of Care and Quality of Life Key Findings**

Only statistically significant increases or declines from 2007 to 2008 are included in this section.

Observed improvements from 2007 to 2008 include (Figure 1.1):

- More incontinent residents had a continence promotion plan
- More residents were assessed for fall risks upon admission or annually
- More advance care plans addressed artificial nutrition and hydration
- More residents were assessed for risk factors for weight loss and dehydration
- More residents diagnosed with anxiety were reassessed every two weeks
- More residents liked the food at their nursing facility
- Increased privacy
  - More residents found a place to be alone when they wished, found a place to visit with a friend in private, and were able to be together in private with another resident
- Increased satisfaction with safety and security
  - More residents felt safe and secure and that their possessions were safe

Observed declines from 2007 to 2008 (Figure 1.1):

- Higher proportion of residents had a Vancomycin-Resistant Enterococcus (VRE) infection
- Fewer residents received care consistent with an advance care document
- Fewer residents participated in religious activities

## **2.0 Methods**

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### **2.1 The 2008 Nursing Facility Quality Review Instrument**

DADS contracted with NACES to collect data about the quality of care and quality of life for individuals who lived in nursing facilities in 2008. NACES reviewers were registered nurses and pharmacists. Reviewers used the 2008 NFQR resident assessment (Appendix A) to collect data from the resident or the resident's family member or guardian, and the resident's medical records.

The 2008 NFQR resident assessment includes a section which asks for the resident's identifying information (i.e., name, date of birth, gender, etc.) and 13 sections with questions related to the following: Urinary Incontinence; Pressure Ulcers; Infectious Illnesses; Pain Assessment and Control; Fall Risk Management; Immunizations; Advance Care Planning; Artificial Nutrition and Hydration; Nutrition, Unintended Weight Loss and Hydration; Medication Practice and Safety; Psychoactive Medications; Restraints; and Quality of Life.

Data regarding Indwelling Bladder Catheter Use was excluded this year because the numbers of residents with indwelling bladder catheters have declined and remain very low. Two new sections were added to the 2008 survey. The two new sections are: Pressure Ulcers and Restraints. Questions regarding Pressure Ulcers were added this year to fulfill provider requests for baseline data. Questions regarding restraints were added to measure the use of restraints in nursing facilities which are affected by the requirements of Senate Bill 325, 79<sup>th</sup> Legislature, Regular Session, 2005.

### **2.2 Sampling**

This year's sample was more representative of the nursing facility population in Texas because residents who recently entered a nursing facility were more likely to be included in the sample. Residents who recently entered a facility were more likely to be selected into the sample because the sample was not drawn until the NACES interviewer visited the facility to administer the NFQR resident assessment. In the past, residents who recently entered a facility were less likely to be included in the sample because the sample was drawn from an existing list of residents and that list did not include individuals who entered the facility after the list was developed.

The sampling frame was developed using the latest facility census data collected from each nursing facility. The census was used to determine facility size. The sample size for each facility was based on the proportion of residents per facility over a four month period and each resident had an equal chance of being selected into the sample. The sample included any individual who had a Minimum Data Set (MDS) assessment at a nursing facility between February and July 2008. The sample size per facility ranged from 1 to 8 individuals:



- 1 individual was selected from facilities with up to 75 residents;
- 2 individuals were selected from facilities with 76-125 residents;
- 3 individuals were selected from facilities with 126-175 residents;
- 4 individuals were selected from facilities with 176-225 residents;
- 5 individuals were selected from facilities with 226-275 residents;
- 6 individuals were selected from facilities with 276-325 residents;
- 7 individuals were selected from facilities with 326-375 residents; and
- 8 individuals were selected from facilities with 376 or more residents.

A list of random numbers was used to determine which resident(s) would be selected into the sample. When the NACES interviewer arrived at the facility, the interviewer was instructed to obtain an alphabetized roster of residents. If the roster was not numbered, the interviewer was instructed to sequentially number the alphabetized roster. The pre-determined randomly selected number was used to determine which resident(s) on the list would be interviewed (i.e., if the random number was 23 then the 23<sup>rd</sup> person on the roster was selected). If the randomly selected resident refused to participate, was not present at the facility, or was deceased, the interviewer used another pre-determined random number to select residents for the sample.

### **2.3 Data Collection**

Thirty-one registered nurses and five pharmacists from NACES completed the NFQR resident assessments this year. NACES submitted all completed NFQR resident assessments to DADS for data analysis.

### **2.4 Data Analysis**

DADS staff analyzed the 2008 NFQR data collected by NACES. Statistical software was used to test for differences in responses to questions asked each year<sup>1</sup>. Most of the quantitative results documented in this report were derived directly from the 2008 NFQR resident assessment survey. The exception includes data which were obtained from the resident's Medication Administration Record (MAR).

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<sup>1</sup> Statistically significant differences not likely due to chance are indicated by an asterisk and corresponding p-value throughout this report. A p-value of <.01 means that there is a 1% chance that the observed difference is likely due to chance and a 99% chance that the observed difference is due to a real effect. The Bonferroni Correction was used as a safeguard against finding false positives with multiple tests on the same data.

### 3.0 Findings

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#### 3.1 Demographics

Eighty-six percent of the residents were age 65 or older and 14% were under age 65. Sixty-nine percent were female and 31% were male. Most of the residents had lived in the nursing facility for a year or more. The distribution of the duration of residency in the nursing facility was as follows:

<u>Amount of time resident lived in nursing facility</u>	<u>Proportion of residents (%)</u>
Less than 3 months	17%
3-6 months	9%
6-9 months	9%
9-12 months	6%
1-2 years	18%
More than 2 years	41%

Findings from this year's NFQR are presented in the order the questions appear in the 2008 NFQR resident assessment (Appendix A). The 13 sections include:

- 3.2 Urinary Incontinence
- 3.3 Pressure Ulcers
- 3.4 Infectious Illnesses
- 3.5 Pain Assessment and Control
- 3.6 Fall Risk Management
- 3.7 Immunizations
- 3.8 Advance Care Planning
- 3.9 Artificial Nutrition and Hydration
- 3.10 Nutrition, Unintended Weight Loss, and Hydration
- 3.11 Medication Practice and Safety
- 3.12 Psychoactive Medications
- 3.13 Restraints
- 3.14 Quality of Life

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### 3.2 Urinary Incontinence

The prevalence of urinary incontinence in residents of nursing facilities is at least 50% nationwide and is a major cause of institutionalization in the elderly (Zimmern, 2001). Continuing urinary incontinence causes embarrassment, reluctance to seek help, and can lead to social isolation and depression. Hence, promoting urinary continence provides both medical and psychosocial benefits.

#### Proportion with Urinary Incontinence

When NACES nurses evaluated the urinary continence status of residents in nursing facilities, the results for Texas indicate that:

- 44% of residents in nursing facilities were observed to be incontinent in 2008 (Figure 3.2). The proportion of residents with incontinence has remained relatively constant since 2004:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
40%	42%	40%	43%	44%

- Of residents who were incontinent this year, 13% had a plan for urinary incontinence and 64% did not. Continence promotion plans involve scheduled and prompted voiding (i.e. assisting the resident to the bathroom at times when the resident is most likely to need to void) and bladder retraining (i.e. teaching the resident to suppress the urge to void) (Cortés & Chou, 2007). The proportion of incontinent residents who did not have a continence promotion plan improved in 2008 compared to 2006 and 2007 (73% did not have a urinary continence plan in either year)<sup>2</sup>.

<u>Of residents who were incontinent:</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Had a continence promotion plan	18%	15%	8%	12%	13%
Did not have a continence promotion plan	67%	71%	73%	73%	64%

Note that the table above only accounts for 77% of incontinent residents in 2008. Twenty-three percent of residents either had a precluding medical condition or refused to use the bathroom (refer to Reasons for Incontinence below).

#### Reasons for Incontinence

Medical reasons, such as a terminal condition or an acute urinary tract infection, may

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<sup>2</sup> Statistically significant at p<.01.



explain why a person has urinary incontinence. Staff knowledge about continence promotion plans and the appropriate method of conducting a prompted or scheduled voiding plan is important in addressing urinary incontinence.

- The data reveal that with the exception of 2005, in 2008, a greater proportion of incontinent residents had a documented precluding medical condition compared to every other year<sup>3</sup>. The data also reveal that this year, significantly more incontinent residents refused to use the bathroom compared to 2005<sup>4</sup>:

<b><u>Reason for urinary incontinence:</u></b>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Had a precluding medical condition	7%	11%	7%	8%	13%
Refused to use the bathroom	9%	4%	12%	8%	10%

### **Effective Urinary Continence Promotion**

While some people with urinary incontinence may benefit from medical testing to diagnose and treat the causes, other people might benefit from an individualized continence plan (Agency for Health Care Policy and Research, 1996).

- Of the residents with urinary incontinence who had a continence promotion plan (13% in 2008), the plan was effective for 6% of those residents (Figure 3.2).

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
5%	5%	9%	3%	6%

The findings suggest that continence promotion approaches are effective for only a limited proportion of residents. Progress in continence promotion will be difficult to achieve until barriers described below are addressed. Reasons why continence promotion plans were ineffective may include but not be limited to the following (Cortés, 2007):

1. Poorly targeted intervention (i.e. a process is needed to purposefully target residents most likely to benefit from a continence promotion plan);
2. Continence promotion plans were not individualized (i.e. continence promotion plans should be tailored to the voiding pattern of each resident);
3. An inappropriately designed plan (i.e. having an every-two-hour voiding plan even though the resident did not need to go every two hours or needed to go more frequently);

<sup>3</sup> Statistically significant at p<.01.

<sup>4</sup> Statistically significant at p<.01.

4. Staff lack of awareness that the resident had a continence promotion plan;
5. Continence promotion plans that were not consistently implemented;
6. Staff turnover;
7. Disproportionate staff-to-resident ratio;
8. Lack of staff training with respect to identifying residents who are most likely to benefit from a continence promotion plan, developing individualized plans, recognizing when a plan exists in the resident's care plan, and consistently implementing plans; certified nursing assistant (CNA) training does not address continence promotion techniques or related steps such as recording a voiding log or conducting a three-day trial of individualized continence promotion;
9. Cognitive and physical abilities of the resident; and
10. Texas Index Level of Effort (TILE) reimbursement rates<sup>5</sup> that provide reimbursement for restorative nursing (e.g. every-two-hour assistance to the bathroom) but no reimbursement for individualized continence promotion plans.

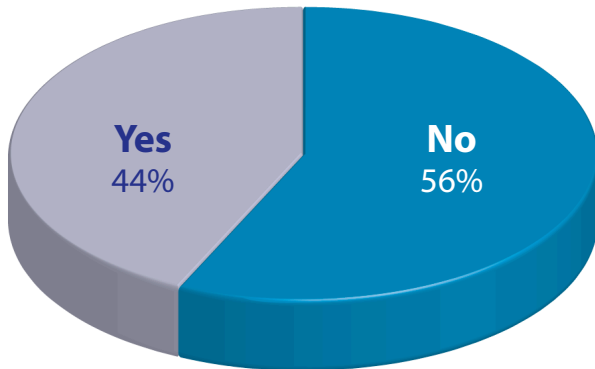
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<sup>5</sup> TILE was still in effect during the time data was collected for NFQR 2008.

## Figure 3.2 – Urinary Incontinence

### Evidence of urinary incontinence?

Was there evidence of urinary incontinence?



[Q2.1]

- The interviewers were asked to determine if they saw, smelled, or felt evidence of urinary incontinence. 44% answered this question “yes” and 56% answered “no” [Q2.1].
- Other questions revealed that:
  - 30% of residents were always continent and did not need a continence plan [Q2.8].
  - 3% of residents were unresponsive (i.e., comatose, semi-comatose, stuporous, persistent vegetative state, unarousable, etc.) and were not expected to be continent [Q2.2].

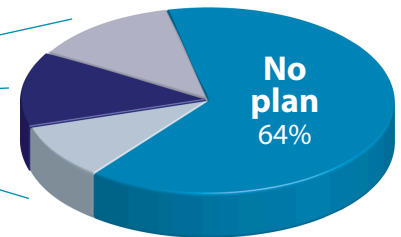
### Of those incontinent (44%)

Did the resident have a continence plan [Q2.6]?

13% Yes, had a continence plan

12% Had a precluding medical condition [Q2.5]

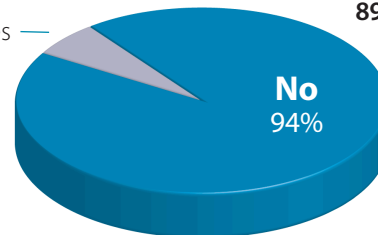
10% Resident refused to use the bathroom [Q2.11]



### Of those who had a continence plan (13%)

Did their continence plan work? [Q2.6 and Q2.9]

6% Yes



89% Had two or more episodes of urinary incontinence in the past two weeks [Q2.9], most episodes (87%) occurred during normal waking hours [Q2.10].



**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

**Survey sample:** 2,129 from 128,971 residents (Medicare, Medicaid, or any other payer source) living in the 1,044 Medicaid certified nursing facilities in Texas.

For further information, contact the **NFQR Project Lead** at 512-438-3472



### **3.3 Pressure Ulcers**

The National Pressure Ulcer Advisory Panel (NPUAP) defines a pressure ulcer as, “a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction (NPUAP, 2007).” Incident rates in long-term care settings range from 2.2% to 23.9% (Lyder, 2003; Duncan, 2007). 2008 marks the first year data was collected about pressure ulcers for the NFQR.

#### **Risk Factors for Pressure Ulcers**

The NFQR defined risk factors for pressure ulcers as:

- Impaired or decreased mobility and decreased functional ability (i.e. uses a wheelchair or walker or being confined to bed);
- Having a co-morbid condition (e.g. diagnosis of end-stage renal disease, thyroid disease, diabetes, peripheral vascular disease, smoking, coronary artery disease, limited mobility, cognitive impairment);
- Use of steroids, which can affect wound healing;
- Exposure of skin to urinary or fecal incontinence;
- Braden score (from a skin assessment) of 16 or lower; and
- A healed pressure ulcer.

NACES interviewers found that 66% of residents in nursing facilities had risk factors for pressure ulcers and 19% had pressure ulcers (Figure 3.3). According to MDS 2.0 Quality Measure/Indicator Report regarding skin care for April through June 2008, 15% of residents in Texas had pressure ulcers (Stage I-IV)<sup>6</sup> (Centers for Medicare and Medicaid Services [CMS], 2008). The national incidence was 17%. The difference in prevalence observed between NFQR and MDS may be due to differences in the way data is collected for each report (i.e. NFQR was collected between February through July 2008 and MDS was collected between April through June 2008; and MDS is self-reported by facilities while NACES reviewers collected NFQR data).

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<sup>6</sup> MDS data is self-reported by Medicare or Medicaid certified nursing facilities



## Treatment Plans for Pressure Ulcers

A treatment plan for pressure ulcers should address risk factors for pressure ulcers. Treatment plans for residents who were at risk for pressure ulcers in 2008 included the following:

<u>Treatment plan to address risk factors for pressure ulcers</u>	<u>2008</u>
Bedridden and repositioned every 2 hours	18%
In chair and able to self-shift weight every 15 minutes	15%
In chair and repositioned by staff every hour	6%
No plan to address risk factors for pressure ulcers	20%
Other	41%

## Pressure Ulcer Staging System

The higher the stage, the more serious the pressure ulcer. Last year, NPUAP revised the pressure ulcer staging system. NPUAP defines pressure ulcer stages in the following way:

- Stage I: “Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area” (NPUAP, 2007).
- Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough (i.e. a mass of dead tissue separating from an ulcer). May also present as an intact or open/ruptured serum-filled blister (NPUAP, 2007).
- Stage III: “Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling” (NPUAP, 2007).
- Stage IV: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar (i.e. a scab formed especially after a burn or cauterization) may be present on some parts of the wound bed. Often include undermining and tunneling (NPUAP, 2007).

## Highest Stage Pressure Ulcer

Nineteen percent of residents had a pressure ulcer this year. For residents who had a pressure ulcer, the location of the highest stage pressure ulcer was as follows: 58% were located on the buttock or lower back, 36% were located on the feet or legs, two percent were located on the arms or hands, and the remaining four percent were in other locations on the body (Figure 3.3). Eighty-nine percent of these residents had a treatment plan in place. The distribution of the highest stage pressure ulcer documented was:

<b><u>Highest stage pressure ulcer</u></b>	<b><u>2008</u></b>
Stage I	34%
Stage II	42%
Stage III	13%
Stage IV	11%

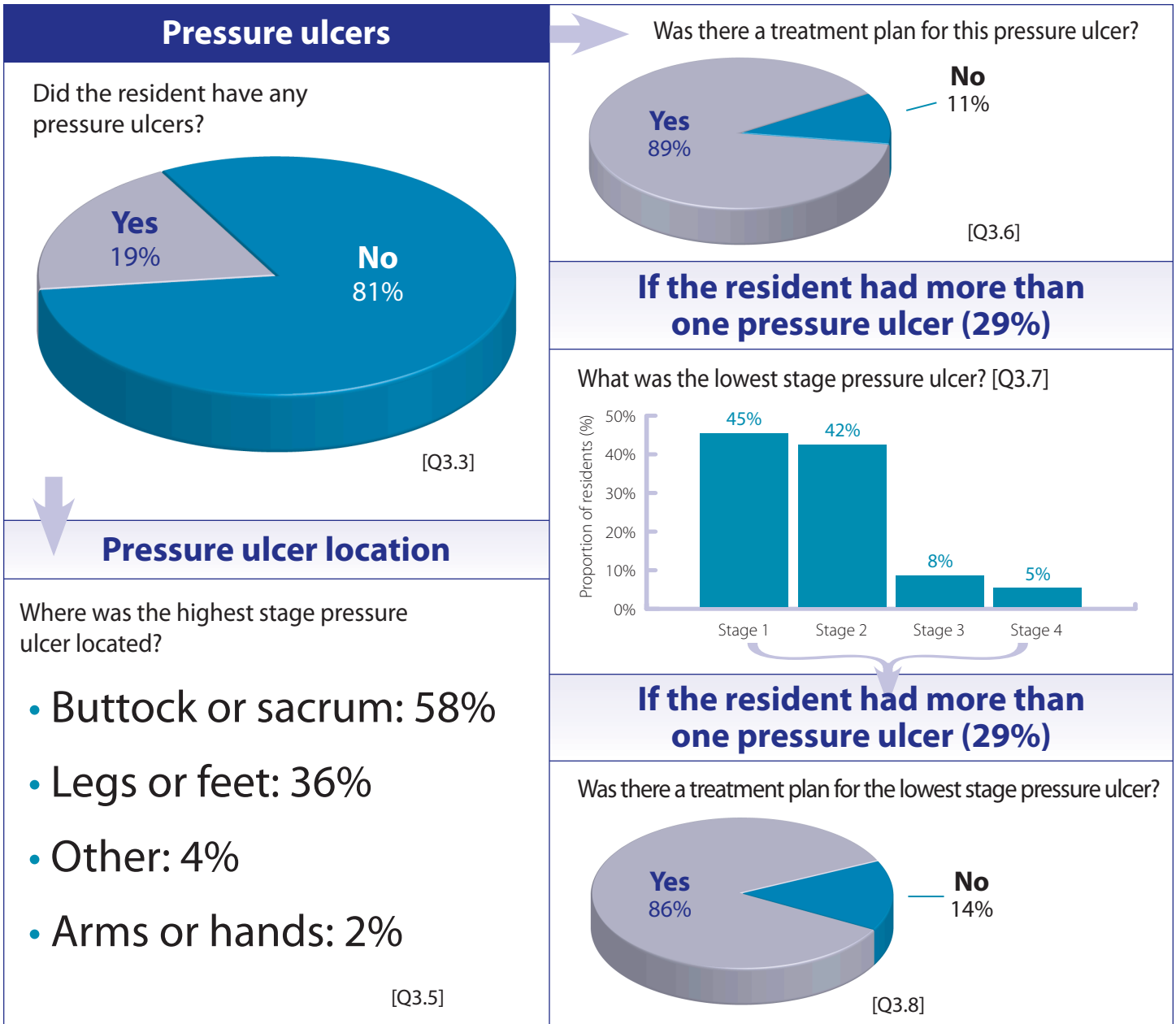
If the resident had more than one pressure ulcer, interviewers documented both the highest and lowest stage pressure ulcer. Of the 19% of residents who had a pressure ulcer, 29% had more than one pressure ulcer.

### **Lowest Stage Pressure Ulcer**

Eighty-six percent of residents had a treatment plan for the lowest stage pressure ulcer (Figure 3.3). The distribution of the lowest stage pressure ulcer documented was:

<b><u>Lowest stage pressure ulcer</u></b>	<b><u>2008</u></b>
Stage I	45%
Stage II	42%
Stage III	8%
Stage IV	5%

## Figure 3.3 – Pressure Ulcers



**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)  
**Survey sample:** 2,129 from 128,971 residents (Medicare, Medicaid, or any other payer source) living in the 1,044 Medicaid certified nursing facilities in Texas.

For further information, contact the **NFQR Project Lead** at 512-438-3472



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### 3.4 Infectious Illnesses

Prevention and control of infection and the reduction of antibiotic resistant strains of bacteria are important in any institutionalized setting. Infection with antibiotic resistant strains requires more complex treatment regimens. When an individual with a resistant organism is treated with an ineffective antibiotic, the organism continues to infect the patient, could potentially spread to other patients, and further compounds the resistance problem (Tenover, 2008). Infectious illnesses have the potential to affect many individuals in communal living environments, like nursing facilities. The spread of infectious illnesses is especially concerning when infected individuals are frail or medically compromised (Strausbaugh, 2003).

#### Types and Rates of Infection in Nursing Facilities

Results from the NFQR resident assessment indicate that the proportion of residents with an infectious illness, including single or multiple infections in a single individual, has steadily increased since 2006. In 2008, 13% of residents living in nursing facilities had an infection in the past seven days (Figure 3.4):

<b><u>Proportion of residents with an infectious illness in the past 7 days</u></b>	<u>2006</u>	<u>2007</u>	<u>2008</u>
	10%	11%	13%

Infectious illnesses occur frequently in nursing facilities. Typical infections include urinary tract infections, skin and soft tissue infections, or pneumonia (Nicolle, 1996). The NFQR resident assessment indicates a slight increase in urinary tract infections, skin infections, pneumonia, diarrhea, and fever in 2008 compared to 2006 and 2007:

<b><u>Proportion of residents with infectious illness</u></b>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Urinary tract infection	4.0%	4.0%	5.0%
Skin infection	2.0%	2.0%	3.0%
Pneumonia	0.7%	0.9%	2.0%
Diarrhea and fever	0.0%	0.1%	0.3%
Other infection	4.0%	5.0%	4.0%

#### Resistant Infectious Agents

The use of broad spectrum antibiotics has been attributed to antibiotic-resistant microorganisms (Weiner, 1999). “Antibiotic resistance occurs when bacteria change in some way that reduces or eliminates the effectiveness of drugs, chemicals, or other agents designed to cure or prevent infections” (CDC, 2008). Two of the most prevalent bacteria exhibiting antibiotic resistance are Methicillin Resistant Staphylococcus Aureus (MRSA) and Vancomycin Resistant Enterococcus (VRE). These types of resistant infections are most commonly found in skin infections, deep tissue wounds, or abscesses. This year,

reported cases of antibiotic-resistant illnesses increased compared to previous years (Figure 3.4):

<b><u>Antibiotic-resistant infection</u></b>	<u>2006</u>	<u>2007</u>	<u>2008</u>
MRSA Infection	0.4%	0.3%	0.4%
VRE Infection	0.1%	0.0%	0.4%

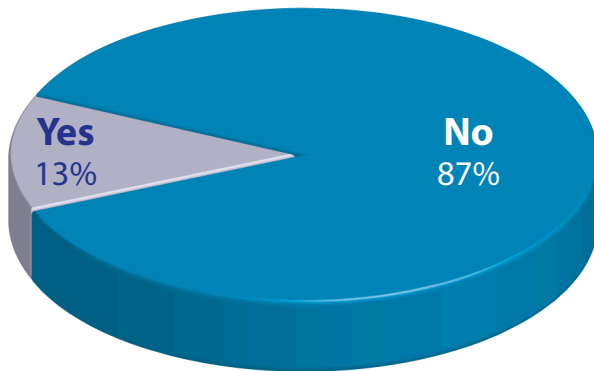
Significantly more VRE infections were reported for residents in 2008 compared to 2007<sup>7</sup>.

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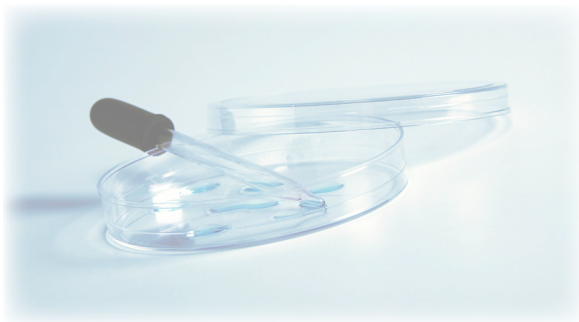
<sup>7</sup> Statistically significant at  $p < .01$ .

## Figure 3.4 – Infectious Illnesses

Did the resident have an infection in the past seven days?



- 5% had a urinary tract infection [Q4.1]
- 3% had a skin infection [Q4.2]
- 2% had pneumonia [Q4.3]
- 0.3% had diarrhea and fever [Q4.4]
- 4% had "other" infection [Q4.5]

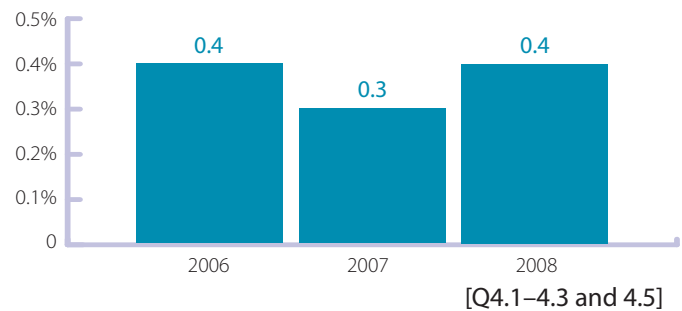


### Antibiotic resistance

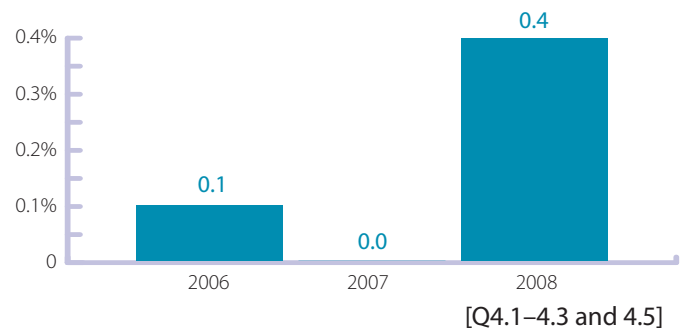
Infectious agents are becoming increasingly resistant to antibiotics; two of the most prevalent are:

- Methicillin-Resistant Staphylococcus Aureus (MRSA)
- Vancomycin-Resistant Enterococcus (VRE)

### How many infections were MRSA?



### How many infections were VRE?



**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

**Survey sample:** 2,129 from 128,971 residents (Medicare, Medicaid, or any other payer source) living in the 1,044 Medicaid certified nursing facilities in Texas.

For further information, contact the **NFQR Project Lead** at 512-438-3472



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### 3.5 Pain Assessment and Pain Control

A structured program for routine pain assessment is a key element in effective pain management (Ferrell, 1995). In the last several years, the NFQR survey has been designed to more closely examine pain assessment and pain control for residents in nursing facilities. Two key elements of successful pain assessment are to (1) use a validated pain assessment tool and (2) consistently use the same appropriate tool for each resident.

#### Use of Pain Assessment Tools

NACES interviewers reviewed medical charts to determine if validated pain assessment tools were being used. Interviewers found that nursing facilities used both observational and self-reported assessment tools. Observational assessment tools included either the Pain Assessment in Advanced Dementia (PAINAD) Scale or the Assessment of Discomfort in Dementia (ADD) Protocol. Self-reported pain assessment tools included the Wong-Baker Faces Pain Scale, Pain Thermometer, Verbal Description Tool, or a Numeric 0-10 Rating Scale.

- Survey results indicate that a validated assessment tool was used to assess pain in 70% of nursing facility residents. Results also indicate that validated assessment tools were used more often in 2008 compared to 2004, 2005, and 2006<sup>8</sup>:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
56%	59%	40%	71%	70%

#### Consistent Use of Pain Assessment Tools

Using an appropriate tool consistently is important because repeated use of the same tool each time an individual is assessed for pain increases the reliability of the assessment.

- Survey results indicate that a validated assessment tool - observational or self-reported - was used consistently in 64% of all pain assessments done in nursing facilities (Figure 3.5). Consistent use of validated tools to assess pain was significantly higher in 2008 than in 2004, 2005, and 2006<sup>9</sup>:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
42%	39%	35%	64%	64%

---

<sup>8</sup> Statistically significant at p<.01.

<sup>9</sup> Statistically significant at p<.01.

**Reliable Pain Assessment Results**

- Interviewers used the Wong-Baker tool to measure residents’ current level of pain. Sixty-five percent of residents reported no pain. Significantly more residents reported moderate to worst pain in 2008 than in 2004 or 2005<sup>10</sup>.

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
7%	7%	9%	10%	10%

**Pain Control**

- In 2008, 65% of residents in nursing facilities who reported being in moderate to worst pain also reported being satisfied with their treatment for pain (Figure 3.5):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
64%	55%	63%	60%	65%

**Frequency of pain assessment**

- In 2008, a new question regarding frequency of pain assessment was added to the NFQR survey. Results indicate that 54% of all residents in nursing facilities who reported moderate to worst pain were assessed for pain every shift. Twenty-one percent of residents were assessed for pain before pain medications were administered and seven percent were assessed after pain medications were administered:

<u>Every shift</u>	<u>Every day</u>	<u>Once a week</u>	<u>Once a month</u>	<u>Before pain medications</u>	<u>After pain medications</u>
54%	4%	4%	9%	21%	7%

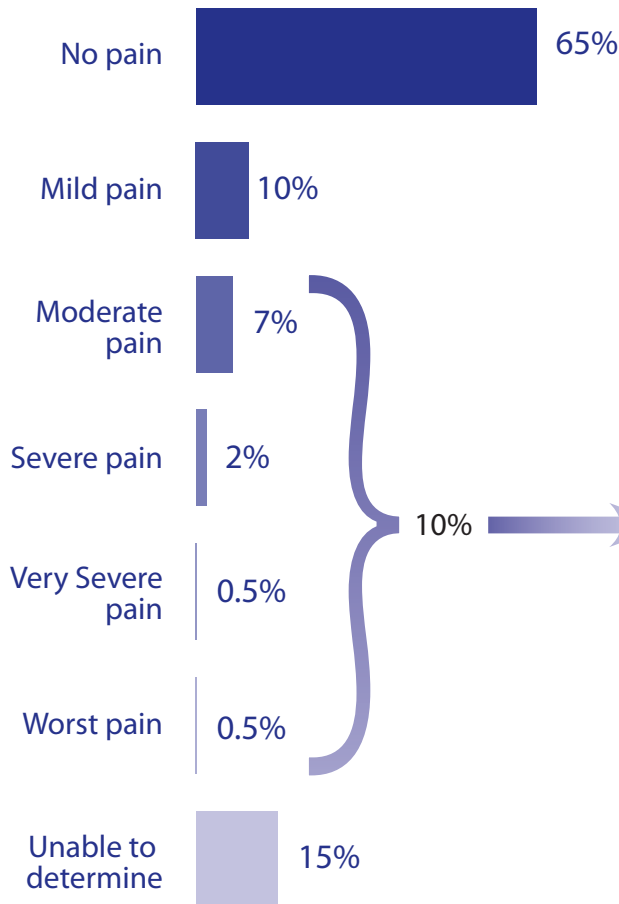
Ideally, 100% of residents should be assessed for pain both before and after pain medications are administered.

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<sup>10</sup> Statistically significant at p<.01

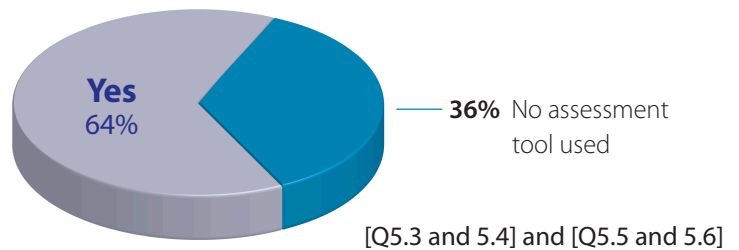
## Figure 3.5 – Pain Assessment and Control

What was the resident's level of pain on the Wong-Baker Faces Pain Scale [Q5.1]?



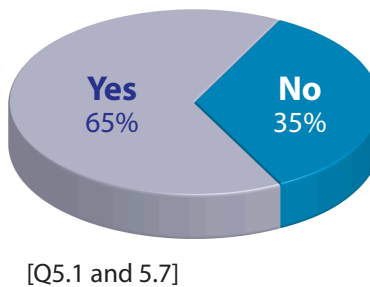
### Reliability of pain assessment

Was a validated pain assessment tool used consistently with a specific resident?



### Of residents in moderate to worse pain (10%)

Was the resident satisfied with the level of pain relief in the last 24 hours?



**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)  
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### 3.6 Fall Risk Management Practices

Falls are a major health problem in older adults. A combination of health and environmental factors are associated with the risk of falling including: advancing age, medication use, cognitive impairment, and sensory defects (e.g., hearing loss and balance impairment). Sixty percent of residents in nursing facilities in the United States fall each year (Fuller, 2008).

#### Preventing Falls: The Fall Risk Assessment

Most falls can and should be prevented (Scott & Rajabai, 2007). Successful fall prevention requires a thorough clinical assessment of residents who fall (or who have a history of falls) and their environment. DADS Quality Monitoring Program (QMP) Resources, Managing Fall Risk states that every resident should have a fall risk assessment upon admission to a long-term care facility (DADS, 2008). Traditional approaches to fall reduction include: education, exercise, medication review, and reduction of fall hazards. Performing assessments to measure the risk of falling is important to develop individualized care plans to reduce the risk of fractures and other fall-related injuries.

- NFQR results indicate that nursing facilities in Texas have greatly improved their efforts to assess residents for fall risks over the past several years. This year, 79% of all residents were assessed for fall risks within 14 days of admission or within 14 days of an annual assessment:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
60%	65%	58%	64%	79%

Significantly more residents were assessed for fall risks upon admission to the facility or annually in 2008 than in any other year<sup>11</sup>.

#### Fall and Fracture Rates

- Seven percent of residents in nursing facilities fell during the past 30 days (Figure 3.6). The proportion of nursing facility residents who fell during the past 30 days declined from 10% in 2005 to 7% this year:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
9%	10%	8%	8%	7%

---

<sup>11</sup> Statistically significant at p<.01.

### Reassessment after a fall

- Of the 7% of residents who fell within the past 30 days, 51% were reassessed for fall risks within 24 hours to determine if contributing factors for falling were resolved (Figure 3.6):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
31%	48%	36%	46%	51%

Significantly more residents were reassessed within 24 hours of a fall in 2008 compared to 2004<sup>12</sup>. While the proportion of residents who were reassessed after a fall has increased during the past 3 years, these results indicate that 39% of all residents still need to be reassessed after a fall.

---

<sup>12</sup> Statistically significant at  $p < .01$

## Figure 3.6 – Fall Risk Management

### Fall risk

- Older people have decreased bone densities and are more prone to fracture if they fall.\*
- Fall prevention strategies can reduce suffering and save money.\*
- The 2008 fall rate in Texas nursing facilities is 10.8%.<sup>+</sup>

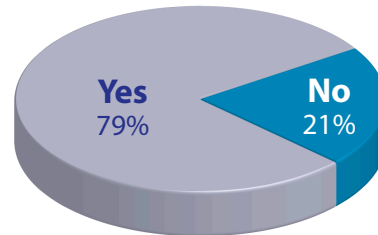


\*Centers for Disease Control  
([www.cdc.gov/nceh/dls/osteoporosis.htm](http://www.cdc.gov/nceh/dls/osteoporosis.htm))

+ Minimum Data Set

### For residents admitted to nursing facility

Was fall risk assessed within 14 days of admission?

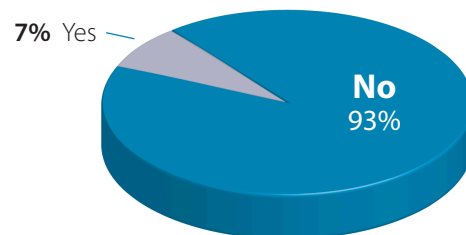


[Q6.1]



### For current residents in nursing facilities

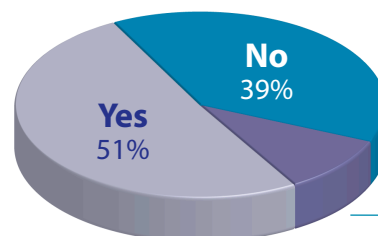
Has there been a fall in the past 30 days?



[Q6.2]

### Of residents who fell in the past 30 days (7%)

Was a fall assessment done within 24 hours of the fall?



[Q6.3]

10% Sent to hospital

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### 3.7 Immunization Practices

In April 2008, a National Vital Statistics Report ranked influenza and pneumonia the 8<sup>th</sup> leading cause of death among the total population in the United States (National Vital Statistics Report, 2008). The Centers for Disease Control and Prevention (CDC) states the best way to prevent influenza is to get vaccinated for influenza each year. The CDC currently recommends that everyone over age 50 be vaccinated for influenza (CDC, 2008).

Some forms of bacterial pneumonia can be prevented with the pneumococcal polysaccharide vaccine (PPV). PPV protects against 23 types of pneumococcal bacteria. Most healthy adults who get the vaccine develop protection to most or all of these types of pneumococcal bacteria within two to three weeks of getting the shot (CDC, 1997). PPV may be less effective in some people, especially those with lower resistance to infection. But these people should still be vaccinated because they are more likely to get seriously ill from pneumococcal disease.

The CDC recommends that everyone over age 65 receive a one-time pneumococcal vaccination (CDC, 1997). The *Healthy People: 2010* objective for pneumococcal and influenza vaccinations of residents in nursing facilities is set at 90% (US DHHS, 2008 and CDC, 2008).

#### Influenza Vaccinations

Influenza, also called the "flu," is a highly contagious respiratory infection. The flu is spread easily from person to person primarily when an infected person coughs or sneezes.

- Residents in nursing facilities who received the flu shot in 2008 decreased by 1% compared to last year (Figure 3.7):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
59%	62%	76%	75%	74%

The proportion of residents in nursing facilities who received the flu shot was higher than the state and national vaccination prevalence rate for the general population. Prevalence data from 2007 of Texans age 65 and older who had a flu shot within the past year was 67% (CDC, 2008). The 2007 national prevalence of adults age 65 and older in the general population who had a flu shot within the past year was 72% (CDC, 2008).

Of the residents who were not vaccinated in 2008 (33%): 56% had no contraindication, did not refuse, and were therefore eligible to receive the influenza vaccine; 44% refused the vaccine or had a contraindication to the vaccine (41% refused, 1% had a contraindication, and 2% both refused and had a contraindication to the flu shot).

Compared to previous years, the proportion of residents who refused the flu shot or who had a contraindication in 2008 was as follows:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
12%	16%	31%	40%	26%

### **Pneumococcal Vaccinations**

CDC data from 2006 indicate that 5,000 people die from invasive pneumococcal disease each year; nearly half are older adults.

- The proportion of residents over age 65 with documentation that a pneumococcal vaccination was given was significantly greater in 2008 than in 2004 and 2005<sup>13</sup> (Figure 3.7):

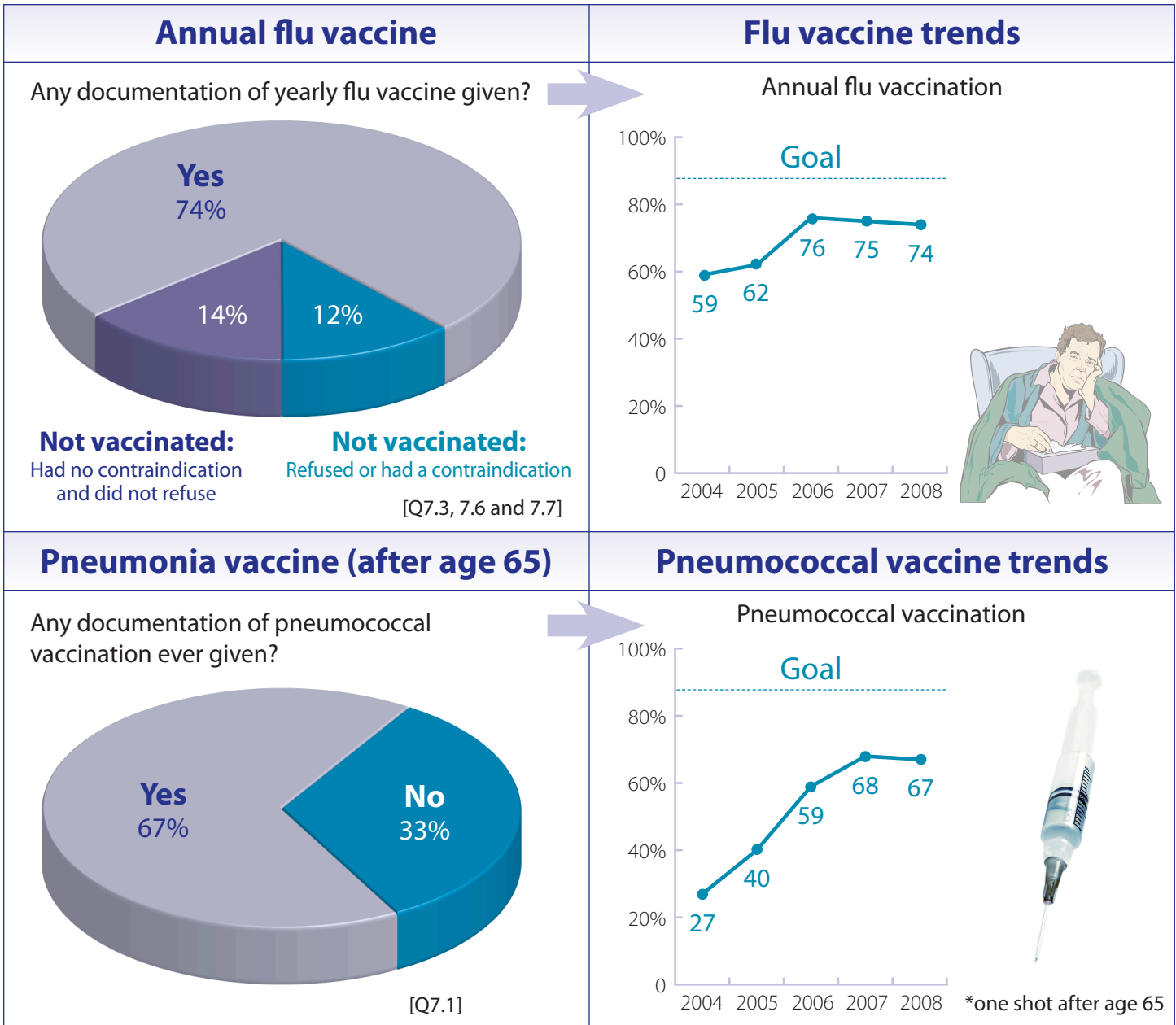
<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
27%	40%	59%	67%	67%

The proportion of residents in nursing facilities over age 65 who ever received a pneumococcal vaccination was higher than the state prevalence and the same as the national rate in 2007. State prevalence data from 2007 of adults age 65 and older who ever had a pneumonia vaccination was 63% (CDC, 2008). The national prevalence of adults age 65 and older who ever had a pneumonia vaccination in 2007 was 67% (CDC, 2008).

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<sup>13</sup> Statistically significant at  $p < .01$ .

## Figure 3.7 – Immunizations



**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)

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### 3.8 Advance Care Planning

Advance care planning involves making decisions about the medical care an individual wants to receive if that individual becomes unable to speak for him or herself. An advance care directive documents the choices an individual makes during the advance care planning process. Individual choices include:

- *Heroic measures*: Do everything, including cardiac defibrillation (i.e., electric shocks to the heart), ventilation for respiration, and administration of medications;
- *Limited heroic measures*: Cardiopulmonary resuscitation (CPR) and medications but no cardiac defibrillation or ventilator; or
- *Palliative care*: Comfort measures only; usually combined with a do-not-resuscitate (DNR) order.

#### Proportion with an Advance Care Document

- Significantly fewer residents had an advance care document in 2008 compared to 2007.

<u>2006</u>	<u>2007</u>	<u>2008</u>
68%	69%	68%

#### Care Consistent with Advance Directive

- Of residents with advance care documents, fewer received care that was consistent with the directive in 2008 than in 2005 or 2007<sup>14</sup>:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
98%	99%	96%	99%	97%

#### Other Advance Care Document Options

- This year, slightly more than half of all residents with an advance care document had an out-of-hospital DNR option (Figure 3.8):

<u>2006</u>	<u>2007</u>	<u>2008</u>
55%	57%	52%

---

<sup>14</sup> Statistically significant at p<.01

In 2008, significantly fewer residents had an out-of-hospital DNR than in 2007<sup>15</sup>.

- Nearly one of every four residents with an advance care document had a directive which addressed artificial nutrition and hydration:

<u>2007</u>	<u>2008</u>
16%	24%

Significantly more residents had advance care plans which addressed artificial nutrition and hydration in 2008 than in 2007<sup>16</sup>.

### **The Durable Medical Power of Attorney**

The durable medical power of attorney document identifies whom an individual chooses to make medical decisions when that individual is no longer able to make decisions for him or herself.

- The proportion of residents with a durable medical power of attorney document rose 1% in 2008 compared to last year (Figure 3.8):

<u>2006</u>	<u>2007</u>	<u>2008</u>
29%	29%	30%

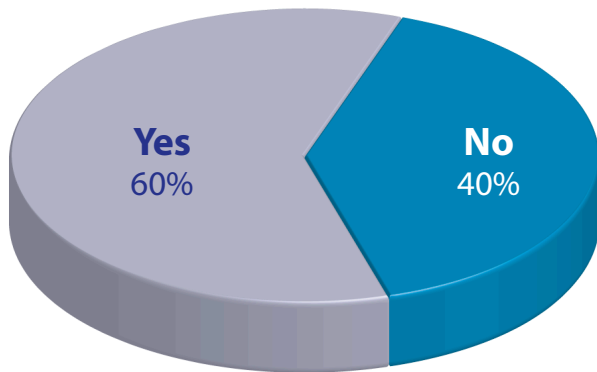
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<sup>15</sup> Statistically significant at p<.01

<sup>16</sup> Statistically significant at p<.0001

## Figure 3.8 – Advance Care Planning

Do residents have any type of advance care document?



[Q8.1a, b, d and e]

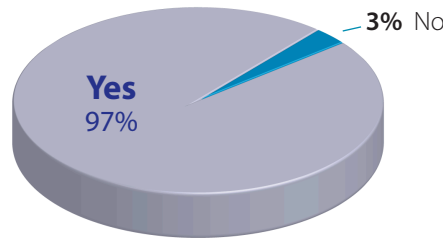
**Types of advance care documents:**

- Out-of-hospital do-not-resuscitate
- Directive to physicians
- Do-not-resuscitate (DNR)
- Other intervention limiting orders

**General types of advance care choices:**

- "I want everything done."
- "I want only medications, and no CPR or intubation."
- "I want to allow a natural death: no heroic measures, only comfort medications."

Was care consistent with resident's advance care document?



[Q8.5]



**Residents with a DNR order**

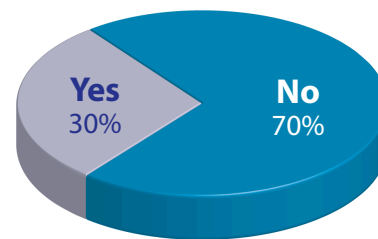
**52%** [Q8.1a]  
Out-of-hospital DNR

**42%** [Q8.1d]  
DNR order

- Complete comfort measures only
- No CPR or lifesaving medications
- No ventilators or defibrillation

**Did the resident have a durable medical power of attorney?**

"Who will make decisions when I can no longer do so?"



[Q8.1c]



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### 3.9 Artificial Nutrition and Hydration

Artificial nutrition and hydration is commonly called tube feeding. The most common method of administering artificial feeding and hydration is to use a Percutaneous Endoscopic Gastrostomy tube. The tube is surgically inserted through an opening in the abdominal skin directly into the stomach.

This year, data regarding consent to place a feeding tube was removed because consent to place a feeding tube is usually obtained in the hospital, not at the nursing facility. Since hospital medical records are not always transferred with residents when they enter a nursing facility, information regarding consent to place a feeding tube would not necessarily be documented in the resident's records at the nursing facility.

#### Proportion with a Feeding Tube

- Review of the NFQR data indicates that the proportion of nursing facility residents in Texas who received artificial nutrition and hydration through a feeding tube is relatively low and has changed very little over the past four years. Eight percent of residents received tube feedings this year (Figure 3.9):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
8%	7%	8%	8%

#### Use of a Feeding Tube for More Than 30 Days

Residents with a feeding tube in place for 30 days or longer need to be assessed every 30 days by nursing facility staff to ensure that nutritional goals are being met.

- In 2008, 53% of nursing facility residents with a feeding tube in place for 30 days or longer were reassessed in the past 30 days (Figure 3.9):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
41%	17%	56%	53%

#### Feeding Tube in Place but Not Used

Feeding tubes may be left in place but not used. In this way, residents retain the option of using the feeding tube in the event that the resident is unable to eat or drink by mouth. In 2008, a small proportion of residents had a feeding tube in place but was not tube fed in the past 30 days; only 2% did not use the tube for more than 30 days:

<u>2007</u>	<u>2008</u>
6%	2%

## Feeding Tubes and Residents who have Dementia or are at the End-of-Life

As with the previous four years, NFQR 2008 evaluated whether residents with the following conditions had a feeding tube:

- Late stage dementia (e.g., non-verbal or non-ambulatory);
- End-stage metastatic cancer or organ failure; or
- Poor performance status on Eastern Cooperative Oncology Group (ECOG) performance scale
  - The ECOG scale is used “to assess how a patient’s disease is progressing, how the disease affects the daily living activities of the patient, and determines appropriate treatment and prognosis” (ECOG, 2008).

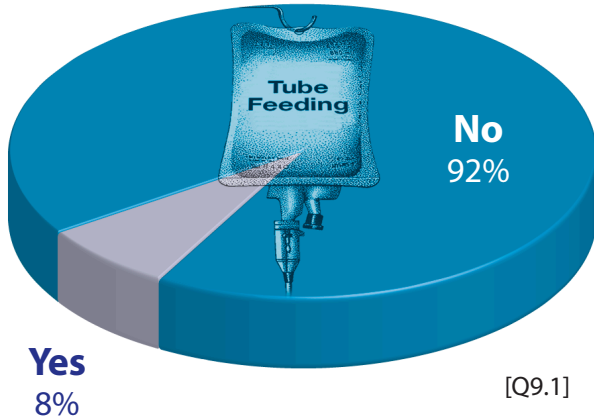
Results indicate that the proportion of residents who received artificial nutrition and hydration and who had late-stage dementia or end-stage illness related to advance cancer increased by nine percent from last year to 40% this year (Figure 3.9):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
38%	31%	31%	40%

## Figure 3.9 – Artificial Nutrition & Hydration

### Tube feeding

Did the resident receive tube feedings?



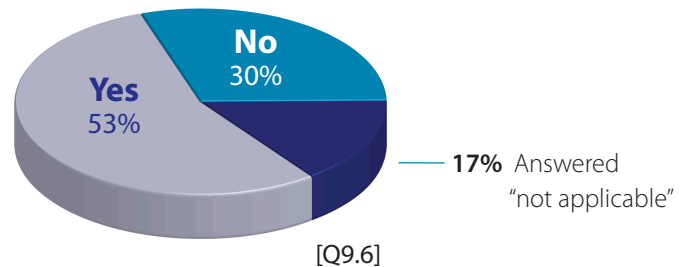
- Tube feeding supplies nutrition via an artificial or mechanical means into the digestive tract. The most common route of tube feeding is the percutaneous endoscopic gastrostomy (PEG) tube:

- A PEG tube is surgically placed from an opening through the abdominal skin directly into the stomach.



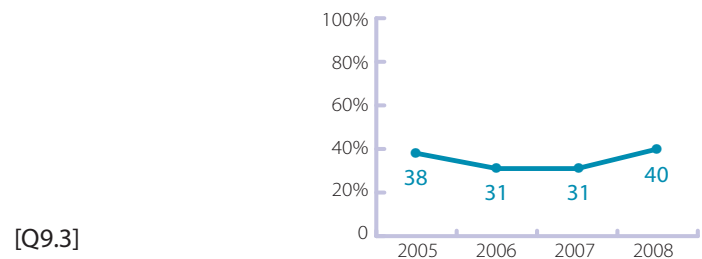
### Of residents who received tube feedings > 30 days

Were their nutritional goals regularly assessed?



### Of residents who received tube feedings

Proportion with late-stage dementia or end-stage illness related to advanced cancer



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### 3.10 Nutrition, Unintended Weight Loss, and Hydration

Nutritional assessments are intended to ensure that residents' nutritional needs are met and to prevent unintended weight loss. Unintended weight loss can contribute to an overall medical condition called sarcopenia, which is the loss of muscle and strength, and is linked to poor balance, decline in gait speed, and increased falls and fractures (Castillo, 2003). Malnutrition and unintended weight loss are also associated with increased hospitalizations, risk of pressure ulcers, infection rates, heart failure, and mortality. The most common causes of unintended weight loss are cancer, gastrointestinal disorders, endocrine diseases, infections, medications, cardiovascular disease, and nervous system disorders, including depression (Hall, 2003).

#### Proportion with a Comprehensive Nutritional Assessment

- The proportion of residents in 2008 who had a comprehensive nutritional assessment done on admission or annually did not change from 2007 (Figure 3.10):

<u>2007</u>	<u>2008</u>
93%	93%

- The proportion of residents whose nutritional assessment included estimating nutritional needs increased by 8% in 2008 to 97% (Figure 3.10):

<u>2007</u>	<u>2008</u>
89%	97%

#### Risk Factors for Weight Loss and Dehydration

Risk factors for weight loss include confusion, dementia, poor oral hygiene or missing teeth, dysphagia (difficulty swallowing), and an inability to feed oneself. Risk factors for dehydration include difficulty holding a glass or swallowing, swallowing only thickened liquids, age greater than 85, use of diuretics, confusion, and dementia.

- The proportion of residents who were assessed for risk factors for weight loss increased by 4% to 69% in 2008 compared to 2007:

<u>2007</u>	<u>2008</u>
65%	69%

- Significantly more residents were assessed for risk factors for dehydration in 2008 than in 2007<sup>17</sup>.

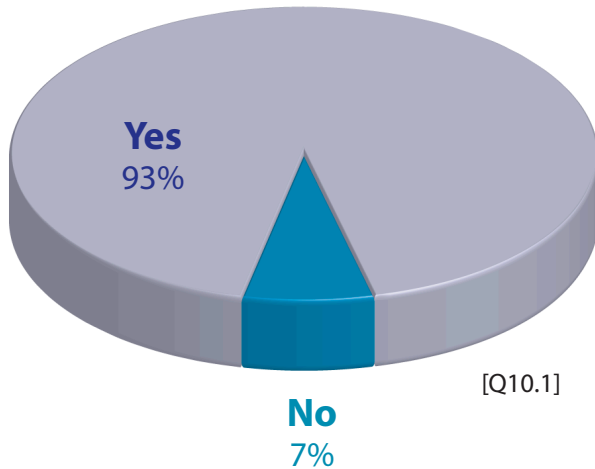
<u>2007</u>	<u>2008</u>
53%	63%

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<sup>17</sup> Statistically significant at  $p < .001$

## Figure 3.10 – Nutrition, Unintended Weight Loss & Hydration

Did the resident have an initial or annual nutritional assessment?

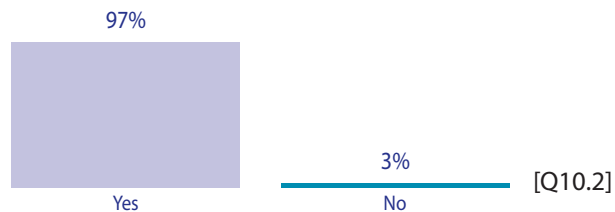


- Unintended weight loss can directly affect overall endurance and resistance to disease.



### For all residents

Did the initial or annual assessment include estimating the resident's nutritional needs?

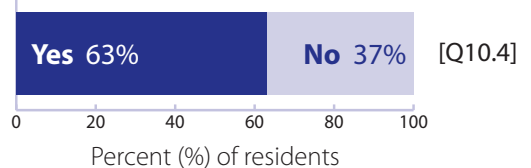


### Assessing risk factors

For unintended weight loss



For dehydration



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### **3.11 Medication Practice and Safety**

#### **Medication Administration Record (MAR)**

The MAR is a record of drugs administered to an individual at a facility by a nurse or other health care professional. The nurse or health care professional signs off on the record at the time that the drug is administered.

The resident's physician determines and orders the specific prescription and over-the-counter substances needed and delegates administration of the prescribed items to the nursing facility staff. Staff annotates every prescription and over-the-counter substance given to the resident, including the dosage, date, and time of administration on the MAR.

#### **3.11.1 Prescribed Medicines**

NACES pharmacists reviewed MARs for data regarding medicines. In general, medication practice in nursing facilities in Texas has changed very little, if at all, during the past several years.

#### **Number of Medications and Over-the-Counter Substances Combined**

The average number of prescription medicines and over-the-counter substances physicians authorized in 2008 has not changed since 2005.

- When NACES pharmacists counted the medications on this year's MARs, the data indicated that physicians prescribed an average of 11 prescription medicines and over-the-counter substances combined per resident, per day:

$\frac{2005}{11}$	$\frac{2006}{11}$	$\frac{2007}{11}$	$\frac{2008}{11}$
-------------------	-------------------	-------------------	-------------------

#### **Prescriptions**

- Each resident was prescribed an average of eight prescription medicines per day:

$\frac{2005}{8}$	$\frac{2006}{8}$	$\frac{2007}{8}$	$\frac{2008}{8}$
------------------	------------------	------------------	------------------

### Number of Active Ingredients in Prescription Medicines

- Some prescription medications combine more than one active ingredient in a single pill or tablet. The actual number of prescribed active ingredients per resident, per day was nine (Figure 3.11):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
9	9	9	9

### 3.11.2 Potential for Drug Interactions and the Top 10 List

#### The Top 10 List of Drug Interactions with the Potential for Adverse Outcomes

A list of medications known to result in adverse outcomes when combined is called the “Top 10” list. Medications chosen for inclusion in the Top 10 list were based on the frequency of use in older adults in long-term care settings and on the potential for adverse consequences if used together (Brown, 2008). The list of Top 10 drug interactions is as follows:

1. Warfarin – Nonsteroidal anti-inflammatory drug (NSAIDS)
  2. Warfarin – Sulfa drugs
  3. Warfarin – Macrolides
  4. Warfarin – Quinolones
  5. Warfarin – Phenytoin
  6. Angiotensin converting enzyme (ACE) inhibitors – potassium supplements
  7. ACE inhibitors – Spironolactone
  8. Digoxin – Amiodarone
  9. Digoxin – Verapamil
  10. Theophylline - Quinolones
- The proportion of residents whose medication regimen included at least one combination from the Top 10 list this year was 12% (Figure 3.11):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
12%	12%	11%	12%

The most common Top 10 drug interaction observed was the use of ACE inhibitors, a blood pressure medicine, combined with a potassium supplement.

- This year nine percent of residents were noted to be on an ACE inhibitor/potassium supplement combination (Figure 3.11):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
9%	10%	9%	9%

- The adverse effects of the ACE inhibitor/potassium supplement combination can be mitigated by using a diuretic. The proportion of residents reported to be on a combination ACE inhibitor/potassium supplement not mitigated by a diuretic in 2008 was two percent, a percent higher than in 2005, 2006, and 2007 (Figure 3.11). Therefore, two percent of residents in nursing facilities in 2008 used an ACE inhibitor/potassium supplement combination and were at risk of a potential adverse outcome:

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
1%	1%	1%	2%

### **Number of Prescribed Medications and the Potential for Drug Interactions**

The number of prescribed medicines is important because the potential for drug interactions and adverse drug reactions increase with the number of medications taken. Research indicates that patients receiving eight or more prescription drugs have a 100% chance of developing a drug interaction (Sloan, 1983).

- The proportion of residents with any Top 10 interaction who also had a prescription for nine or more active ingredients in 2008 was 9%. Compared to previous years, this proportion has remained relatively stable since 2005 (Figure 3.11):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
9%	9%	8%	9%

#### **3.11.3 Beers List**

The Beers list, named for its originator, Mark H. Beers, M.D., is a list of medications that are potentially inappropriate for use in older adults (Fick, 2003). Part of normal aging includes changes in body composition (e.g., percent of fats and fluids) and organ functioning (e.g., how efficiently the stomach absorbs a substance, how the liver processes it, or how effectively the kidney clears it from the bloodstream). These changes can directly affect how an individual will respond or react to a medication. Because of these physiological changes, some medications are known to be potentially troublesome for older adults.

- When the MARs were reviewed this year, the proportion of residents receiving at least one medication from the Beers list was 14%, an improvement of 3% compared to last year (Figure 3.11):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
16%	15%	17%	14%

The most commonly used medication from the Beers list this year was digoxin, a drug which is commonly prescribed for heart failure. Digoxin dosing requires individualized

regimens to ensure optimal drug levels. Inappropriate elevated digoxin levels can lead to increased emergency room visits due to drug toxicity.

### 3.12 Psychoactive Medication Usage

Psychoactive medications include the medication classes of antipsychotics, anxiolytics (anti-anxiety), and sedative/hypnotics (sleep) medications. While there are valid medical indications to prescribe these medicines, caution is urged for use in the elderly, especially in those with cognitive impairment. These medicines can affect alertness which can lead to falls, fractures, hemorrhage, or delirium (Gurwitz, 2000).

#### 3.12.1 Antipsychotic Medications

This class of medicines is appropriate for persons with psychosis, usually seen in persons with schizophrenia, or in persons who have serious personality disorders.

#### Proportion on Antipsychotic Medication(s)

- In 2008, 30% of all residents were prescribed at least one antipsychotic medication, the lowest proportion compared to previous years (Figure 3.12):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
34%	33%	32%	30%

#### Documented Medical Indication for Antipsychotic Medication

Appropriate use of antipsychotic medications is based on a clinical indication for its use. The definition of an appropriate clinical indication for antipsychotic use includes the CMS accepted indications (psychosis, delusions, schizophrenia, specific personality disorders, Tourette's disorder, Huntington's disease, or specified organic brain syndromes), and non-CMS reported indications (paranoia, obsessive-compulsive disorder, impulse-control personality disorder, hemiballismus, and Meige's syndrome).

Specific behaviors which are not appropriate for antipsychotic use include:

- Wandering;
- Poor self-care;
- Restlessness;
- Memory impairment;
- Anxiety;
- Depression without psychosis;
- Insomnia;
- Unsociability;
- Indifference to surroundings;
- Fidgeting or nervousness;
- Uncooperativeness; and
- Agitated behaviors not causing a danger to him or herself or to others.

- NACES pharmacists found that of those who received an antipsychotic medication this year, 65% had an accepted indication (Figure 3.12). Compared to previous years, 65% represents a decrease from last year but an increase compared to 2005 and 2006:

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
58%	59%	71% <sup>18</sup>	65%

### Typical and Atypical Antipsychotic Medications

Antipsychotic medications are divided into two major subgroups: typical and atypical. The typical antipsychotics are older medicines and, while effective, are associated with many side effects. The newer atypical antipsychotics have fewer side effects and are now used more commonly than typical antipsychotic medications.

- Of the residents on antipsychotic medications, 14% were on a typical antipsychotic medication and 92% were on an atypical antipsychotic medication. (Note that the percent of typical and atypical medications sum to more than 100% because residents may have been on both types simultaneously):

<u>Proportion of residents on antipsychotic medications</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Typical	14%	14%	13%	14%
Atypical	93%	94%	92%	92%

Behavioral symptoms, such as hitting, yelling, or screaming, are observed to occur in people who have dementia or who are experiencing pain. Atypical antipsychotic medicines have been used by some physicians in an off-label fashion to control behavioral symptoms (the term “off-label” means a medicine is prescribed for a different medical condition than it was approved for by the Food and Drug Administration [FDA]). Off-label atypical antipsychotic medications used to control behavioral symptoms have been associated with an increased risk of sudden death (U.S. FDA, 2005).

- This year, the proportion of residents on at least one atypical antipsychotic medication without a clinical indication increased by 4% to 33% (Figure 3.12):

<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
41%	41%	29%	33%

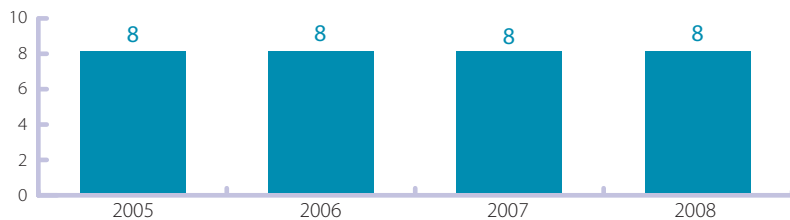
<sup>18</sup> Note that this percentage was reported incorrectly in the 2007 NFQR report. The reported percent was 82% in 2007. The correct percent for 2007 is 71%.



## Figure 3.11 – Medication Practice & Safety

### Prescribed medicines

Average number of prescribed medicines, per resident, per day:

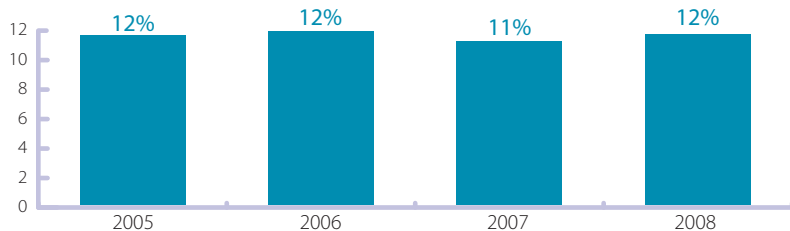


Proportion of residents on nine or more active ingredient medications:

**9%**

### Top 10 drug interactions\*

How many residents' medication regimens included a Top 10 interaction?



Most common Top 10 drug interaction is:

ACE-I plus K+ = 9%

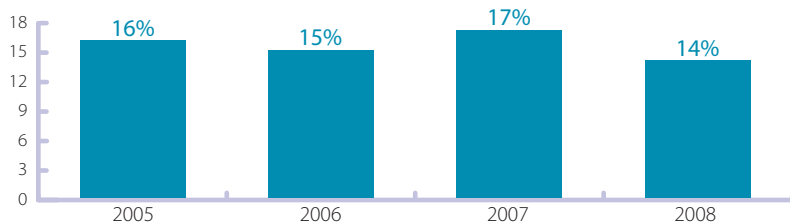
(Angiotensin converting enzyme inhibitor plus potassium)

Not mitigated by a diuretic = 2%

\*Medications associated with adverse outcomes

### Beers List\*\*

How many residents received at least one medication on this list?



Most common medication used on the Beers List:

**Digoxin**

\*\*Medications generally avoided in the elderly

**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)

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### 3.12.2 Anti-Anxiety Medications

#### Medical Diagnosis of Anxiety

While anxiolytic medications are appropriate for managing medically diagnosed anxiety disorders, previous NFQR surveys have noted that these medications were administered to residents without a documented diagnosis of an anxiety disorder.

- NFQR results indicate that in 2008, 16% of all residents had a documented diagnosis of an anxiety disorder. Compared to last year, nine percent more residents had a documented diagnosis of an anxiety disorder (Figure 3.12):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
17%	12%	7%	7%	16%

#### Proportion on Anti-Anxiety Medications

- CMS data indicate that the proportion of residents on anti-anxiety medications in 2008 was 21%, an increase of one percent compared to last year<sup>19</sup> (Figure 3.12):

<u>2007</u>	<u>2008</u>
20%	21%

#### Reassessment of Anxiety Symptoms

- NFQR data reveal that this year marked the highest proportion of residents who were reassessed every two weeks to evaluate anti-anxiety therapy goals. Of the residents diagnosed with an anxiety disorder this year (16%), 54% had an ongoing symptom assessment at least every two weeks to evaluate the stated, measurable goals of anti-anxiety therapy (Figure 3.12):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
45%	23%	6%	19%	54%

Of the residents diagnosed with anxiety, significantly more residents were assessed at least every two weeks for goals of anti-anxiety therapy this year than in the previous three years<sup>20</sup>.

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<sup>19</sup> Note that the reported proportion of residents diagnosed with an anxiety disorder is independent of the reported proportion of residents on anti-anxiety medications. The proportion diagnosed with anxiety was calculated specifically on NFQR data. The proportion on anti-anxiety medications is based on self-reported CMS data from nursing facilities during different times each year. Since the data source, methodology, and sample population are different for the proportion diagnosed with an anxiety disorder and the proportion on anti-anxiety medications, inferences should not be drawn between the two proportions.

<sup>20</sup> Statistically significant at  $p < .01$ .

### 3.12.3 Sedative/Hypnotic (Sleep) Medications

#### Proportion of Residents who Reported Sleep Problems

- Daytime sleepiness and nighttime sleep disturbances are common problems in residents of nursing facilities (Martin, 2006). In 2008, eight percent complained of sleep problems in the past 14 days. This proportion represents an increase of three percent more residents who complained of sleep problems this year compared to last year (Figure 3.12):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
8%	9%	6%	5%	8%

#### Proportion on Sleep Medications

- Compared to 2004, significantly more residents were reported to be on sleep medications this year<sup>21</sup>:

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
11%	16%	13%	13%	15%

#### Effectiveness of Sleep Medications

- This year 28% of residents on a sleep medication reported continuing sleep problems (Figure 3.12):

<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
41%	31%	25%	21%	28%

Compared to 2004, significantly fewer residents reported continuing sleep problems this year<sup>22</sup>. However, 28% indicates that more residents reported continuing sleep problems despite sleep medication this year compared to last year.

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<sup>21</sup> Statistically significant at p<.01.

<sup>22</sup> Statistically significant at p<.01.

## Figure 3.12 – Psychoactive Medications

<b>Antipsychotics</b>	<b>Accepted indication?</b>	<b>Off-label use?</b>
Proportion of residents who received antipsychotic drugs:  <h1>30%</h1>	Of those who received an anti-psychotic drug, how many had an accepted indication?  <h1>65%</h1>	Of those who received an atypical antipsychotic drug, how many did not have a clinical indication?  <h1>33%</h1>
<b>Medical diagnosis of anxiety?</b>	<b>Anxiolytics</b>	<b>Regular reassessment?</b>
Of all residents, how many had a medical diagnosis of anxiety?  <h1>16%</h1> [Q11.1]	Proportion of residents who received anxiolytic drugs:  <h1>21%</h1>	Of those diagnosed with anxiety, how many were reassessed at least every two weeks?  <h1>54%</h1> [Q11.1 and 11.4]
<b>Reported sleep problems?</b>	<b>Sleep medications</b>	<b>Medication effective?</b>
Of all residents, how many reported sleep problems?  <h1>8%</h1> [Q12.1]	Proportion of residents on medications for sleep problems:  <h1>15%</h1> [Q12.3]	Of residents on sleep medications, how many reported continued sleep problems?  <h1>28%</h1> [Q12.3 and 12.1]

**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

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### 3.13 Restraints

CMS defines restraint as, "...any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body" (CMS, 2008). Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions and lap trays that an individual cannot remove. Wheelchair safety bars, chairs, gerichairs, and bedrails that prevent the resident from voluntarily rising are also considered physical restraints. This definition is important because it states that whether or not an object is classified as a restraint depends upon the effect the object has on the resident. CMS defines a chemical restraint as, "...any drug that is used for discipline or convenience and (is) not required to treat medical symptoms."

#### Use of Restraints

The data show that 63% of residents were not restrained in the last 30 days and 29% were restrained (Figure 3.13). Reviewers were not able to determine whether the remaining 8% of residents were restrained. Data analysis also reveals that of those restrained in the last 30 days, 30% of residents were restrained at the request of the resident's family or guardian (Figure 3.13). The data suggests that increased awareness of the risks of restraint use is needed for family members and guardians.

The proportion of residents restrained in 2008 (30%) is greater than reported in previous years because in previous years only limb, waist, and trunk restraints were defined as a restraint. This year, in addition to these types of restraints, full bed rails and other bed rails, personal, and chemical restraints were included in the definition of restraint. When only limb, waist, and trunk restraints were examined for 2008, the data reveal that the prevalence of restraint use continued to decline from 2002 to 2005 (Cortés, 2006). Restraint data were not collected in 2006 or 2007. The observed prevalence of restraint in 2008 was 6.0%.

<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
19.5%	10.7%	8.8%	7.6%	Data not collected	Data not collected	6.0%

#### Type of Restraint Used

Of the 29% of residents who were restrained, 87% were mechanically restrained, 2% were personally restrained, and 2% were chemically restrained. The proportion of residents mechanically restrained were as follows: 58% were restrained by full bed rails, 32% by other types of bed rails, 18% by a chair which prevented rising, 3% by trunk restraints, and 1% by limb restraints (Figure 3.13).

When chemical restraints were used (2%), oral restraints (i.e. oral medications) were used most often (82%), followed by other chemical restraints (27%), and injectable chemical restraints (18%). Note that the proportions sum to more than 100% because a resident could have received more than one type of chemical restraint.

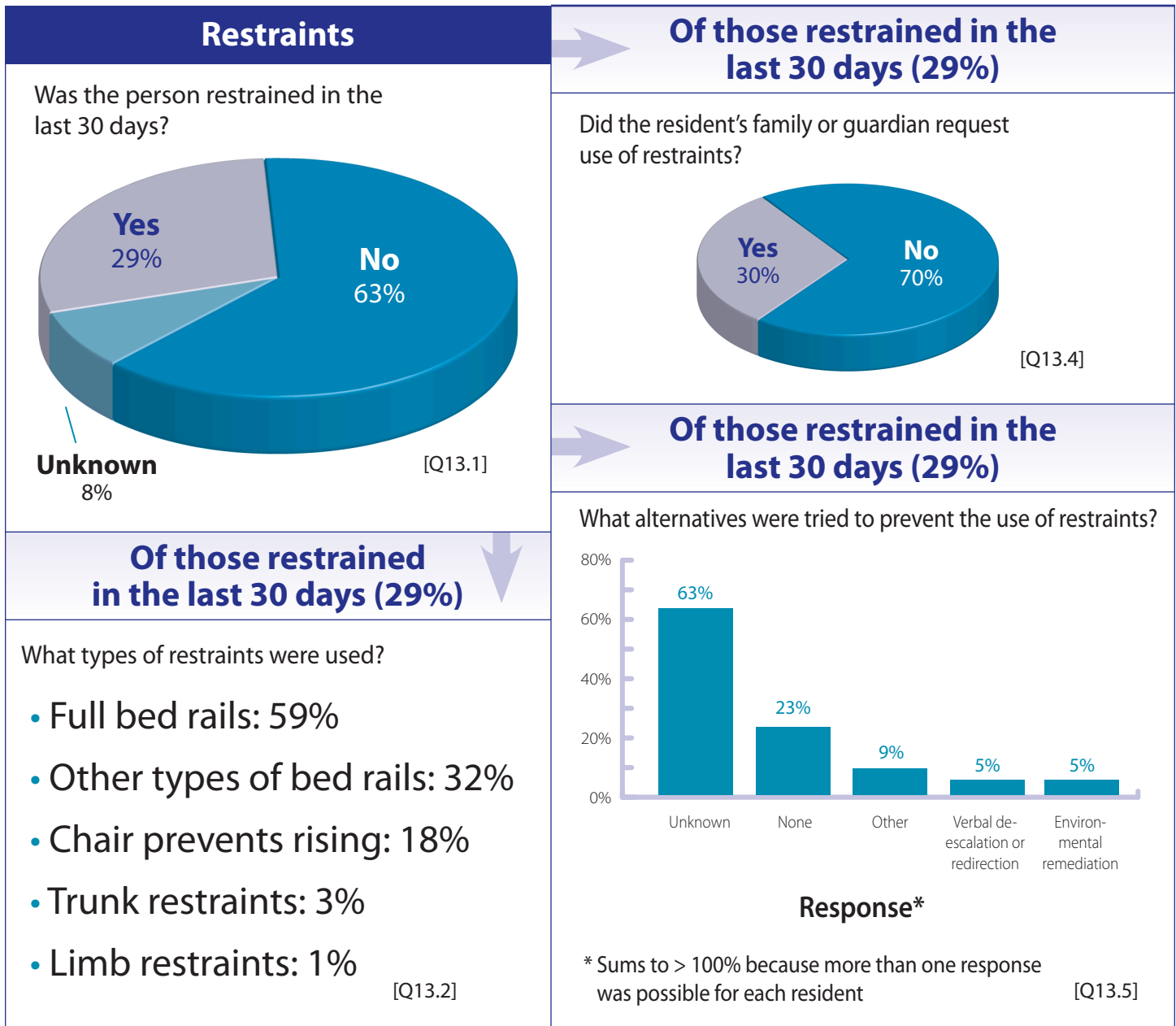
### **Alternatives to Restraints**

The restraint reduction literature identifies adverse effects of restraint use including: loss of physical independence, loss of cardiovascular tone, decreased respiratory efficiency, loss of muscle tone and strength, increased risk of falls and injuries, depression and aggressive behaviors, new-onset cognitive impairment, urinary incontinence, and pressure sores (Terpstra, Terpstra, and Van Doren, 1998; Morse and McHutchion, 1991).

A review of nursing facility records indicate that no alternative method was tried to prevent the use of restraints for 23% of residents who were restrained this year. Other alternatives to prevent the use of restraints were tried for 9% of residents. Verbal de-escalation or redirection, or environmental remediation was tried in 10% of residents to prevent the use of restraints. Reviewers were not able to determine if an alternative was tried to prevent the use of restraints for 63% of residents who were restrained in the last 30 days (Figure 3.13).



## Figure 3.13 – Restraints



**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)

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### 3.14 Quality of Life/Consumer Satisfaction

Quality of life (QOL) is "...[a]n important consideration in medical care... [and] refers to a person's ability to enjoy normal life activities" (MedicineNet.com, 2007). Feeling safe and secure, eating food that is enjoyable in an enjoyable setting, and socializing in activities or choosing private times are basic elements that affect an individual's overall well-being.

Every resident was asked to complete NFQR questions regarding QOL. If after a reasonable attempt the resident was not able to respond, then a resident's family member or guardian was asked to answer the QOL questions. This year, the proportion of individuals who responded to the survey was as follows (Figure 3.14):

- Resident: 69%
- Family member or guardian: 10%
- Neither the resident or a family member responded: 21%

In addition to asking how satisfied residents were with their experience in their nursing facility, this year's survey asked residents to rate their satisfaction with health care services (Figure 3.14). Also, in addition to the topic areas included in last year's report (i.e. food, mealtimes, activities, socialization, privacy, safety, and possessions), this year's survey included questions about the Ombudsman Program. Section 4.1 describes DADS Ombudsman Program.

#### Overall Satisfaction with Experience in Nursing Facility

Eighty-nine percent of residents reported being very satisfied, satisfied, or somewhat satisfied with their overall experience. Nine percent reported being somewhat dissatisfied, dissatisfied, or very dissatisfied this year. Two percent reported being neither satisfied nor dissatisfied and one percent did not answer this question:

<b><u>Overall satisfaction with experience in nursing facility</u></b>	<u>2004</u>	<u>2005</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Very satisfied, satisfied, or somewhat satisfied	91%	91%	84%	87%	89%
Neither (i.e., neither satisfied nor dissatisfied)	1%	2%	7%	2%	2%
Somewhat dissatisfied, dissatisfied, or very dissatisfied	8%	7%	9%	10%	9%
No answer	1%	1%	1%	1%	1%

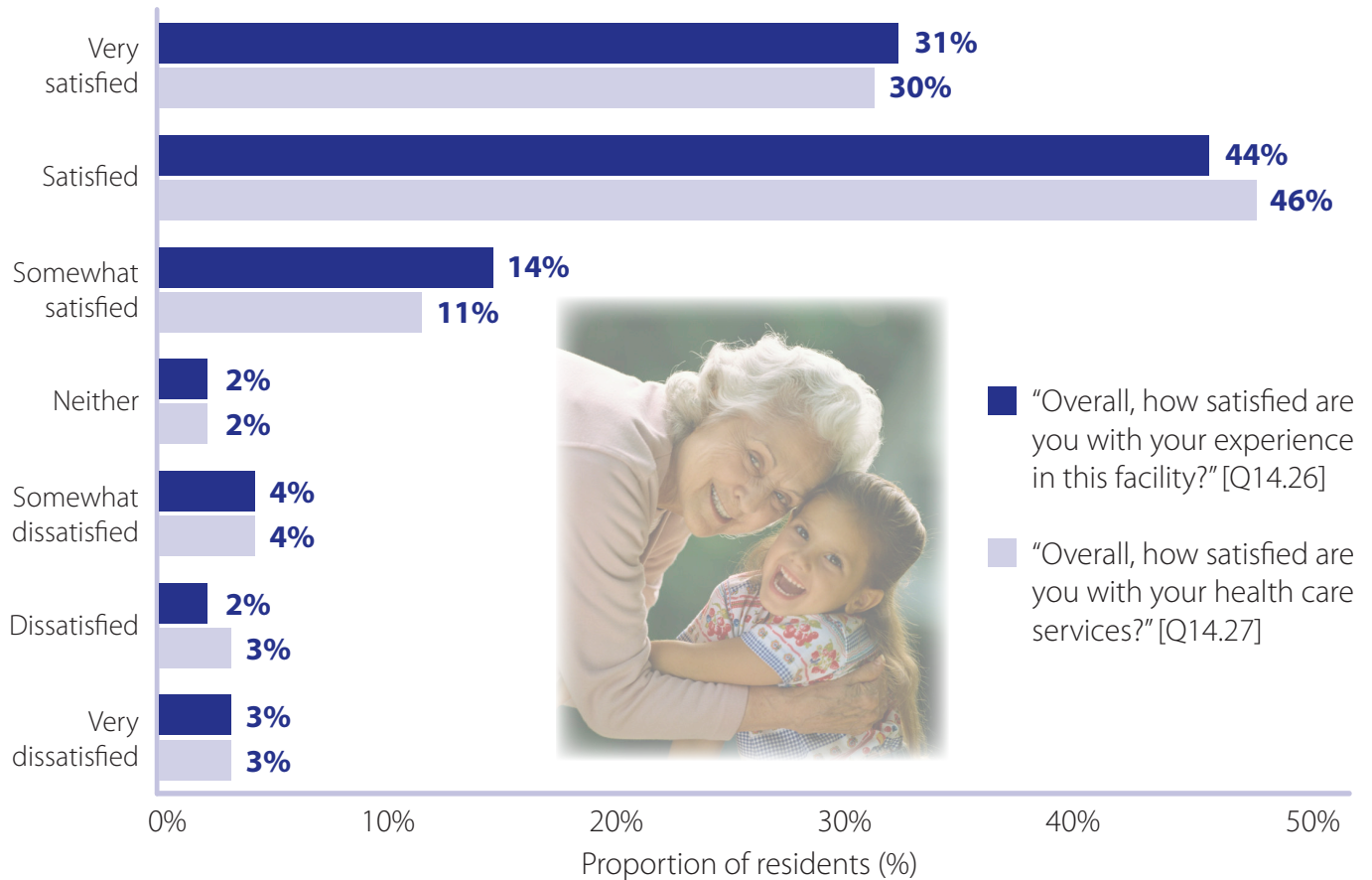
### Overall Satisfaction with Health Care Services

- Residents' overall satisfaction with health care services mirrored results of residents' overall nursing facility experience (Figure 3.14). Eighty-seven percent of residents were very satisfied, satisfied, or somewhat satisfied with their health care services. Ten percent were somewhat dissatisfied, dissatisfied, or very dissatisfied with their health care services. Two percent were neither satisfied nor dissatisfied and one percent did not answer this question:

<b><u>Overall satisfaction with health care services</u></b>	<b><u>2008</u></b>
Very satisfied, satisfied, or somewhat satisfied	87%
Neither	2%
Somewhat dissatisfied, dissatisfied, or very dissatisfied	10%
No answer	1%

## Figure 3.14 – Overall Quality of Life

**Overall, how satisfied are you with your or your family member's experience and health care services in this nursing facility?**



Who completed the survey?

- Resident: 69%
- Family member or guardian: 10%
- Neither the resident nor a family member (not counted in results): 21%

[Q14.1]

**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

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## Satisfaction with Food and Dining Experience

Like the past two years, this year's NFQR survey asked residents three questions regarding food and mealtimes. However, unlike past years, the response choices regarding food and mealtimes, activities, socialization, privacy, safety, and possessions were changed from a choice of "yes"/"no" to a Likert scale (i.e., "always", "sometimes", "rarely", "never", and "no answer"). In order to compare data across the three years of data collected, "always" and "sometimes" were combined into a single response and the combined response was coded as "yes."

- Residents who responded "yes" to the following questions regarding food and mealtimes from 2006 to 2008 were as follows (Figure 3.14a):

<b><u>Food and dining experience</u></b>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Do you like the food here?	80%	78%	84%
Do you enjoy mealtimes here?	85%	85%	87%
Can you get your favorite foods here?	64%	64%	67%

- Significantly more residents reported that they liked the food in the nursing facility this year (84%) compared to last year (78%)<sup>23</sup>. The proportion of residents who reported that they enjoyed mealtimes also increased this year (87% this year compared to 85% in 2006 and 2007). Of all of the food-related questions regarding quality of life, the data suggest that in 2008, two-thirds (67%) of residents were able to get their favorite foods at their nursing facility. This represents a slight increase from the previous two years (64% in 2006 and in 2007) (Figure 3.14a).

---

<sup>23</sup> Statistically significant at  $p < .01$

### Satisfaction with Activities at Nursing Facility

- Residents responded to questions regarding religious and organized activities for each of three years. In 2008, the proportion of residents who responded “yes” to the following questions were as follows (Figure 3.14b):

<u>Activities</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Do you participate in religious activities here?	64%	66%	60%
Do the religious observances here have personal meaning for you?	70%	67%	66%
Do you enjoy the organized activities here at the nursing home?	65%	66%	64%
Outside of religious activities, do you have enjoyable things to do at the nursing home during the weekends?	40%	37%	40%

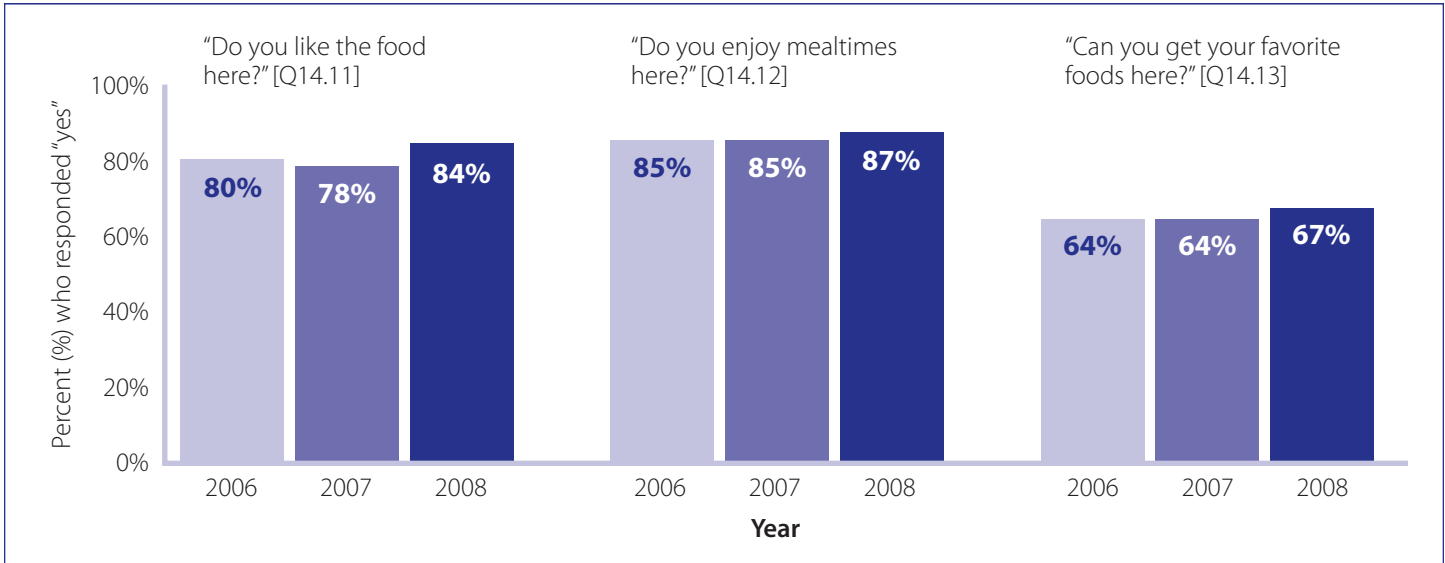
The data reveal that significantly fewer residents reported participating in religious activities at nursing facilities in Texas this year compared to last year<sup>24</sup>. The data also suggest that while more residents enjoyed non-religious weekend activities in 2008 compared to last year, improvement in opportunities for weekend activities are needed.

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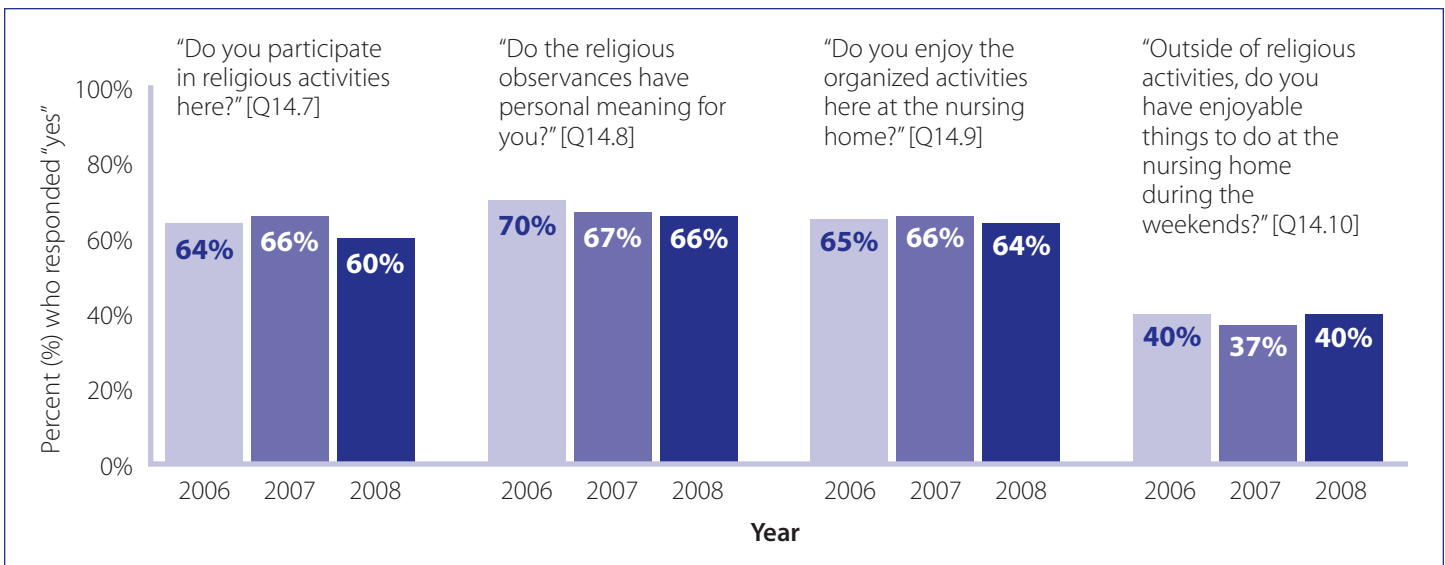
<sup>24</sup> Statistically significant at p<.01



## Figure 3.14a – Quality of Life – Dining Experience



## Figure 3.14b – Quality of Life – Activities



**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

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### Satisfaction with Socialization and Privacy

- With respect to socialization and privacy, residents of nursing facilities responded “yes” to the following questions (Figure 3.14c):

<u>Socialization and privacy</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Can you find a place to be alone when you wish?	82%	72%	78%
Can you make a private phone call?	84%	80%	80%
When you have a visitor, can you find a place to visit in private?	88%	81%	86%
Can you be together in private with another resident (other than your roommate)?	76%	64%	73%

- Privacy indicators improved in 2008 compared to 2007. This year, more residents reported being able to find a place to be alone (78%)<sup>25</sup>, finding a place to visit with a friend in private (86%)<sup>26</sup>, and being together in private with another resident (73%)<sup>27</sup>.

### Satisfaction with Safety, Possessions, and Security

- The proportion of residents from 2006 to 2008 who responded “yes” to the questions regarding safety and possessions are as follows (Figure 3.14d):

<u>Safety and possessions</u>	<u>2006</u>	<u>2007</u>	<u>2008</u>
Do you feel that your possessions are safe at this nursing home?	79%	79%	89%
Have your clothes gotten lost or damaged in the laundry in the last month? <sup>28</sup>	38%	36%	36%
Do you feel safe and secure?	94%	94%	97%

Safety indicators also improved in 2008. This year, significantly more residents reported feeling that their possessions were safe compared to previous years<sup>29</sup>. Significantly more residents also reported feeling safe and secure this year compared to previous years<sup>30</sup>.

<sup>25</sup> Statistically significant at p<.01

<sup>26</sup> Statistically significant at p<.01

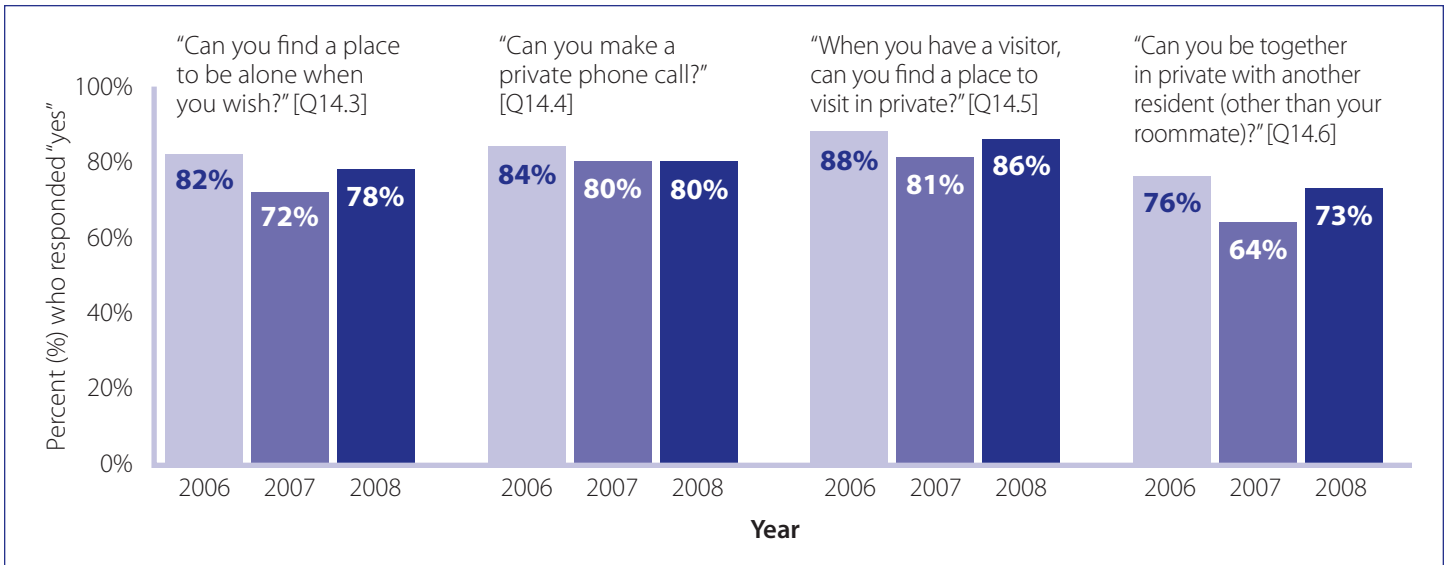
<sup>27</sup> Statistically significant at p<.01

<sup>28</sup> This question was changed in 2008. The comparable question from 2006 and 2007 was, “Do your clothes get lost or damaged in the laundry?”

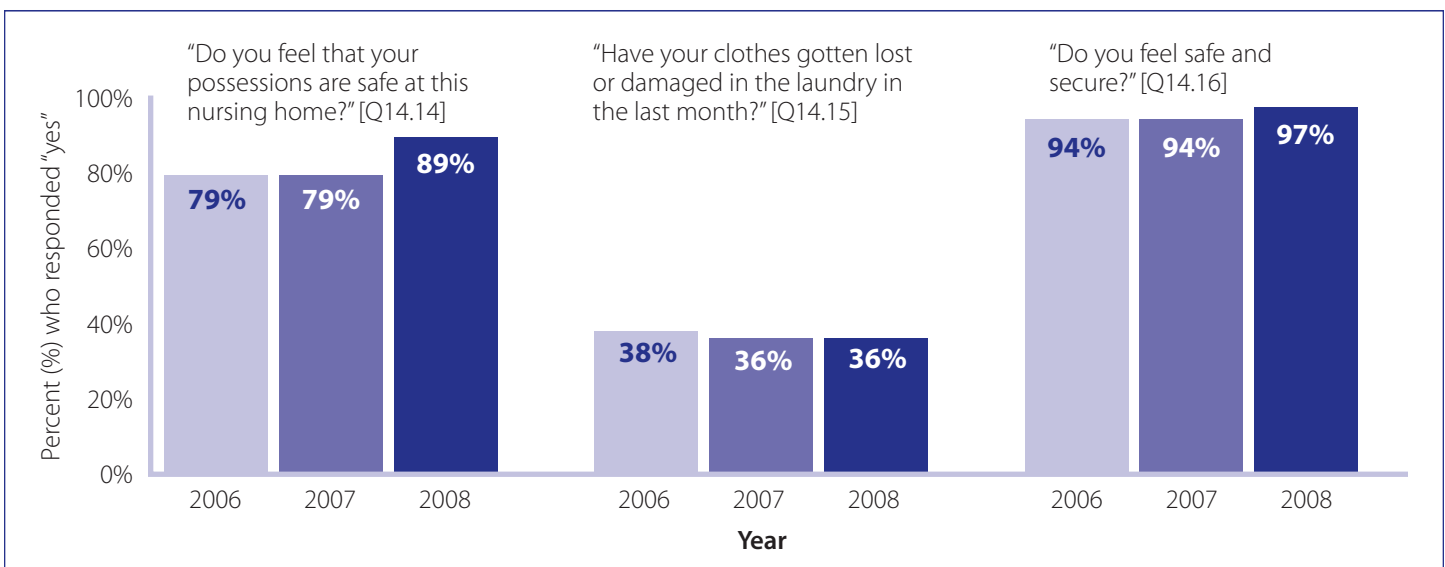
<sup>29</sup> Statistically significant at p<.01

<sup>30</sup> Statistically significant at p<.01

## Figure 3.14c – Quality of Life – Socialization & Privacy



## Figure 3.14d – Quality of Life – Safety & Possessions



**Survey conducted:** February – July 2008 [Q#. #] = Survey question number (Appendix A)

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## Satisfaction with Feeling Safe and Secure

- This year, additional questions were added to the survey regarding safety and security. Residents who reported feeling unsafe and insecure were asked if they felt unsafe and insecure because of direct care staff, other residents, non-care staff, environmental concerns, or other reasons. Of the 3% of residents who reported feeling unsafe and insecure, most reported feeling unsafe and insecure because of direct care staff or other residents:

<b><u>Residents feel unsafe and insecure because of</u></b>	<b><u>2008</u></b> <sup>31</sup>
Direct care staff	33%
Other residents	29%
Non-care staff	13%
Environmental concerns	12%
Other	34%

When residents were asked if they ever had concerns that their facility did not address, 87% reported having no concerns for the facility to address. Ninety-five percent reported not being afraid to express a concern they had because they were afraid of retaliation. Five percent were afraid to express a concern because they were afraid of retaliation (Figure 3.13e).

## Satisfaction with Ombudsman Program

Residents were asked if they had heard of the Long-Term Care Ombudsman Program, if they knew how to contact an ombudsman or if they had used the services of an ombudsman in the past 12 months. The proportion of residents who responded “yes” to each question was as follows (Figure 3.14f):

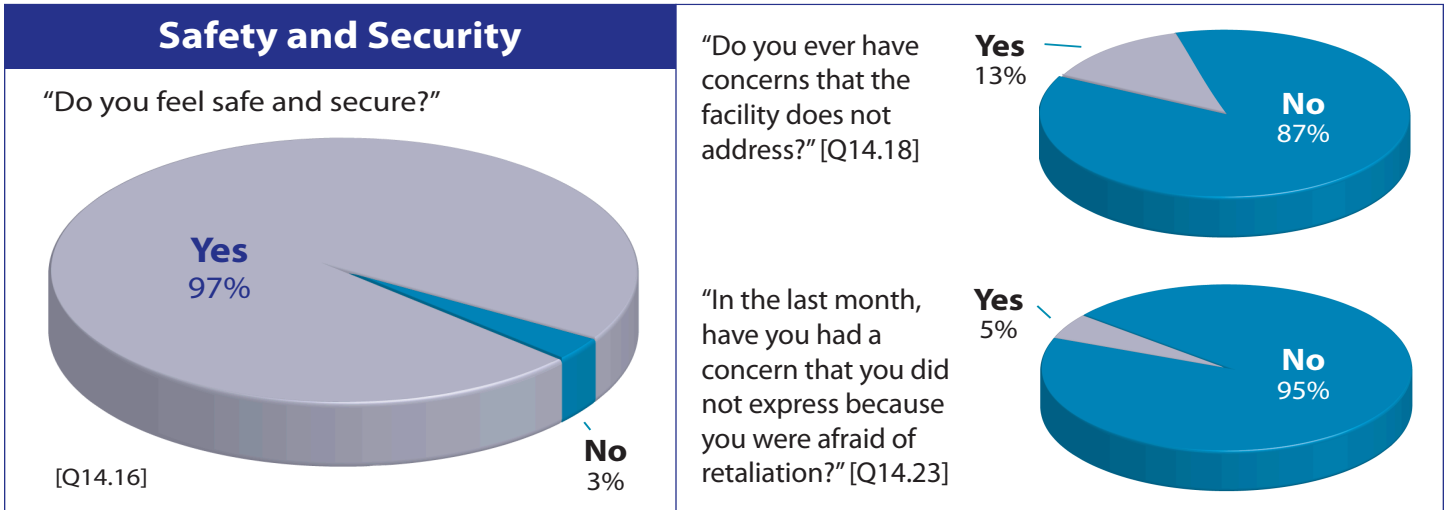
	<u>2008</u>
Have you heard of the Ombudsman Program	16%
Do you know how to contact an ombudsman	7%
Have you used the services of an ombudsman in the last 12 months	2%

Of those who had used the services of an ombudsman, 57% reported that the ombudsman was very helpful, 14% reported that the ombudsman was not helpful and 29% were neutral about whether the ombudsman was helpful (Figure 3.14f).

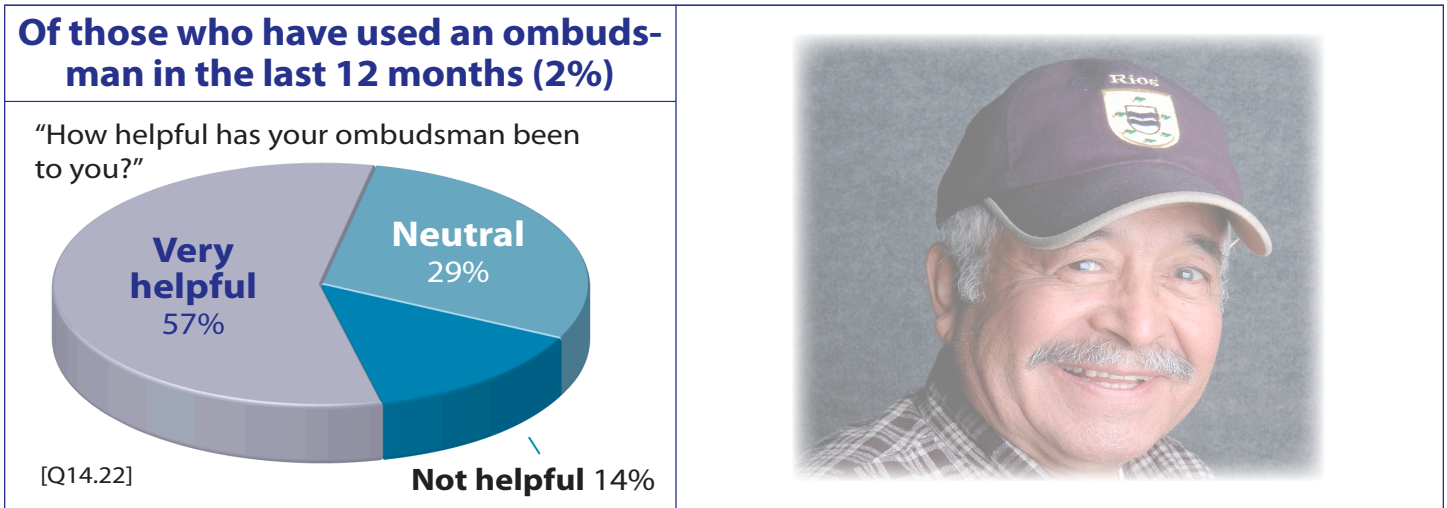
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<sup>31</sup> Note that the percentages sum to more than 100% because question 14.17 on the NFQR survey instructed residents to “mark all that apply.”

## Figure 3.14e – Quality of Life – Safety & Security



## Figure 3.14f – Quality of Life – Ombudsman



**Survey conducted:** February – July 2008 [Q#.#] = Survey question number (Appendix A)  
**Survey sample:** 2,129 from 128,971 residents (Medicare, Medicaid, or any other payer source) living in the 1,044 Medicaid certified nursing facilities in Texas.  
 For further information, contact the **NFQR Project Lead** at **512-438-3472**



#### **4.0 DADS Initiatives and Collaborative Efforts**

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Reported findings from the 2008 NFQR resident assessment indicate whether residents' quality of care and quality of life have improved, stayed the same, or declined over time. DADS will use these findings to update and improve long-term services and supports (LTSS) in Texas. Forums for exchange of information involve DADS collaborative efforts described in this section.

##### **Quality Monitoring Program**

DADS collaborates with providers, medical directors, directors of nursing, and other staff members of nursing facilities through several ongoing programs. One ongoing effort is the DADS Quality Monitoring Program (QMP). QMP staff work directly with nursing facility staff to provide information on evidence-based best practices in over 12 focus areas.

The Quality Monitoring Program (QMP), created by Senate Bill 1839, 77<sup>th</sup> Legislature, Regular Session, 2001, represents an educational, rather than regulatory, approach to quality improvement at nursing facilities. Implementing an educational approach has helped to improve acceptance of the QMP within facilities statewide and has fostered positive partnerships with respect to evidence-based best practices in selected focus areas.

The mission of the QMP is to achieve optimal resident outcomes through the consistent application of evidence-based best practices. The QMP provides technical assistance carried out by registered nurses, pharmacists, and dieticians to nursing facilities. Focus areas include those described in this report:

- Improving continence promotion for residents who experience urinary incontinence;
- Reducing infectious illnesses;
- Improving assessment and management of residents who have pain;
- Managing fall risks;
- Improving vaccination rates;
- Ensuring that artificial nutrition and hydration is used only when it will benefit residents;
- Improving routine hydration practices and preventing unintended weight loss;
- Reducing polypharmacy;
- Reducing the use of unnecessary psychoactive medications; and
- Restraints.

In 2009, QMP plans to deploy two new focus areas including:

- Reducing the risk of pressure ulcers; and
- Assisting facilities to meet end-of-life care wishes for their residents through advance care planning.

## **Long-Term Care Ombudsman**

This is the first year that DADS Long-Term Care (LTC) Ombudsman Program was included in the NFQR. The Ombudsman Program advocates for residents on a variety of issues related to quality of care and quality of life in nursing facilities. The LTC ombudsmen educate residents, families, and staff of nursing facilities on subjects such as resident rights, care plans, and communication. LTC ombudsmen are trained on “culture-change” to promote individual freedom and choice for residents.

This year’s NFQR survey assessed whether residents had ever heard of the Ombudsman Program, if they knew how to contact an ombudsman, and if they had ever used the services of an ombudsman in the last 12 months. Results suggest that individuals who live in nursing facilities are not familiar with the term “ombudsman” and do not know how to contact an ombudsman if needed.

As a result, in 2009, the Long-Term Care Ombudsman Program will update the program’s poster, brochures, and other educational materials in an effort to build program awareness in facilities. Nursing facilities are required to provide educational materials created by the Long-Term Care Ombudsman Program to residents upon admission. Additional educational materials are distributed directly to residents by the ombudsman during visits to facilities. These materials reinforce a connection between the term “ombudsman” and the purpose of the Long-Term Care Ombudsman Program.

## **Advance Care Planning Pilot Project**

The DADS Advance Care Planning Pilot Project (SB 27, 80<sup>th</sup> Legislature, Regular Session, 2007) will inform and provide data to review and analyze the outcome of education on advance care planning provided to residents and families of residents in nursing facilities and intermediate care facilities for persons with mental retardation. A report of the pilot project is due to the Governor and the Legislature by October 2010.

## **Texas Falls Prevention Coalition**

DADS Quality Assurance and Improvement Unit (QAI) sponsors a collaborative partnership between the Texas Association of Area Agencies on Aging (T4A) and Texas A&M Health Science Center School of Rural Public Health, called the Texas Falls Prevention Coalition (TFPC). The Coalition began in June 2007 and is charged with improving fall prevention and changing attitudes and behaviors that predispose older persons to falls.

Sessions are planned to promote the view that falls and fear of falling are controllable, help participants modify their environment to reduce fall risk factors, and teach strength and stability exercises to improve balance, reaction time, and overall muscle tone. The program will be disseminated statewide through a train-the-trainer effort and will ultimately reach local communities and seniors.

QAI will extend its current contract with T4A and TFPC for an additional year, allowing TFPC to augment program reach and increase the impact on the health of aging Texans. The original contract included 17 Area Agencies on Aging (AAA) and 147 counties. The expansion will allow the TFPC and the evidence-based “A Matter of Balance,” a fall prevention program, to be available in 25 of the 28 AAA regions in Texas and an additional 72 counties. At the conclusion of the contract in August 2009, the falls prevention program will have expanded to 220 of the 254 counties in Texas. The program may also be replicated in nursing facilities.

### **Aging Texas Well (ATW)**

The purpose of DADS ATW initiative is to identify and discuss aging policy issues, guide state government readiness, and promote increased community preparedness for an aging Texans. The ATW initiative aims to expand regional public/private evidence-based health promotions to help Texas seniors take control of their lives and reduce the risk of disease and disability. “Aging Texas Well means that Texans prepare for aging in all aspects of life and that state and local social infrastructure facilitates aging well throughout the lifespan” (DADS, 2005).

DADS is preparing a report on the 2008 ATW Indicators Survey which was used to collect information on how well aging Texans are doing based on self-reported key indicators of successful aging. In August 2008, DADS published the ATW Plan 2008-2009 (DADS, 2008). The stated objectives include updating the ATW Plan every two years, developing easy-to-read resource briefs to support a basic understanding of complex aging and gerontological topics, sharing resources, and providing technical assistance to other agencies.

### **Geriatric Symposium**

In September 2008, DADS QAI unit held its 8<sup>th</sup> annual Geriatric Symposium. This year’s theme was, “Rethinking Dementia Care: Providing a Supportive Environment,” and focused on treatment and intervention for aging Texans. Geriatric professionals disseminated best practices in caring for individuals who have cognitive impairments to over 280 nursing facility administrators, directors of nursing, social workers, therapists, and physicians. This year’s NFQR will help DADS identify topic areas for future meetings. Next year’s symposium is scheduled for September 21, 2009.

### **Nursing Home Quality Improvement Coalition (NHQIC)**

The NHQIC is a group of nursing home-related organizations in Texas focused on improving the quality of care for all residents of nursing facilities. Results from the NFQR will be shared with NHQIC to inform the group of quality of care issues in Texas for 2008.



Members of the NHQIC include:

- Texas Health Care Association
- Texas Association of Homes and Services for the Aging
- Texas Department of Aging and Disability Services
- AARP/Texas
- Texas Medical Directors Association
- TMF Health Quality Institute
- Membership from the provider community

On July 14, 2008 NHQIC held, “Meet at the Bedside: Envision Texas without Pressure Ulcers” to disseminate best practices on pressure ulcers. The daylong event brought hospitals, home health agencies, hospice providers, and nursing homes from all over the state together.

## **5.0 Conclusion**

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In addition to an individual's personal health, support network, and physician, the nursing facility and its staff, as well as state and federal regulations impact an individual's overall experience in a nursing facility. The 2008 NFQR assessed the quality of care and quality of life of a sample of more than 2,000 individuals who resided in nursing facilities in Texas in 2008.

Survey results indicate that most individuals were satisfied with their overall experience and health care services in their nursing facility this year. Quality of care improvements noted this year compared to last year include a higher proportion of residents who were incontinent and had a continence promotion plan, residents assessed for fall risks, advance care plans which addressed artificial nutrition and hydration, residents assessed for the risk for weight loss and dehydration, and reassessments of residents on anti-anxiety medications. Quality of life improvements included increased privacy and satisfaction with safety and security.

Quality of care areas that showed declines include the need to address antibiotic resistant infections, the proportion of residents with an advance care document, care consistent with an advance care document, and social and recreational activities offered at nursing facilities.

This review contributes to the knowledge base that helps inform policy making for the growing aging population. This information is shared not only internally at DADS but also with providers and fosters open communication and collaboration to improve the quality of care and quality of life of the people DADS serves.

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## Part 2. Assessment of Urinary Continence

Questions 2.1 through 2.8 MUST BE ANSWERED. Questions 2.9 through 2.11 MUST BE ANSWERED when the answer to 2.8 is NO.

**NOTE:** Perform a continence check (**ITEM 2.1**) on every resident in the sample prior to collecting the remaining data items for any resident.

### 2.1\* Did you find (see, smell, or feel) evidence of urinary incontinence?

- <sup>1</sup> Yes (44%)                       <sup>2</sup> No (56%)

**2.2\* Is the resident unresponsive (usual baseline level of responsiveness is comatose, semi-comatose, stuporous, persistent vegetative state, unarousable, etc.)? (This does NOT mean, “Is the resident cognitively impaired.” One can be very impaired and still not be unresponsive.)**

- <sup>1</sup> Yes (3%)                       <sup>2</sup> No (97%)

**2.3\* In your professional opinion, does this resident require a mechanical lift or 2-person assistance to get out of bed?**

- <sup>1</sup> Yes (31%)                       <sup>2</sup> No (69%)

**2.4\* Is the resident unable to ambulate or sit for ANY routine daily activity due to pain?**

- <sup>1</sup> Yes (4%)                       <sup>2</sup> No (96%)

**2.5\* Does the resident have a terminal condition or palliative plan of care that precludes toileting?**

- <sup>1</sup> Yes (11%)                       <sup>2</sup> No (89%)

**2.6\* Is a toileting plan (prompted voiding-PV, scheduled voiding-SV or bladder retraining-BR) specifically documented as part of the resident’s care plan? (NOTE: If more than one applies, answer with first answer from the list that applies to this resident)**

- <sup>1</sup> Yes-PV (3%)                       <sup>2</sup> Yes-SV (10%)  
 <sup>3</sup> Yes-BR (1%)                       <sup>4</sup> No (86%)

**2.7\* Is the plan based on the individual’s voiding pattern and needs?**

- <sup>1</sup> Yes (7%)                       <sup>2</sup> No (2%)  
 <sup>3</sup> q2h SV (6%)                       <sup>4</sup> There is no plan (85%)



**2.8\* Is the resident ALWAYS continent *without needing* a toileting plan, incontinence products or a catheter?**

- <sup>1</sup> Yes (30%)                       <sup>2</sup> No (70%)

----- If item 2.8 was answered YES, then skip to Part 3 -----

**2.9 Have there been two or more episodes of urinary incontinence each week in the last two weeks?**

- <sup>1</sup> Yes (89%)                       <sup>2</sup> No (11%)

**2.10 Have any of these episodes occurred during normal waking hours?**

- <sup>1</sup> Yes (87%)                       <sup>2</sup> No (13%)

**2.11 Does the resident refuse to use the toilet and all toileting devices? (e.g. BSC, urinal, bedpan)**

- <sup>1</sup> Yes (10%)                       <sup>2</sup> No (90%)

### **Part 3. Pressure Ulcers**

Question 3.1 must be answered.

**3.1\* Does the resident have risk factors for a pressure ulcer?**

- <sup>1</sup> Yes (66%)                       <sup>2</sup> No (34%)

-----If item 3.1 was answered NO, then skip to 3.3.-----

**3.2 Does the treatment plan address (check one):**

- <sup>1</sup> Bedridden and Repositioned every 2 hours? (18%)
- <sup>2</sup> In chair and able to self shift weight every 15 minutes? (15%)
- <sup>3</sup> In chair and repositioned by staff every 1 hour? (6%)
- <sup>4</sup> There is no plan (20%)
- <sup>5</sup> Other (41%)

**3.3 Does the resident have any pressure ulcers?**

- <sup>1</sup> Yes (19%)                       <sup>2</sup> No (81%)

----- If item 3.3 was answered NO, then skip to Part 4.-----

**3.4 What is the next highest stage pressure ulcer they have?**

- <sup>1</sup> Stage 1 (34%)                      <sup>2</sup> Stage 2 (42%)  
<sup>3</sup> Stage 3 (13%)                      <sup>4</sup> Stage 4 (11%)

**3.5 Where is the highest stage pressure ulcer located?**

- <sup>1</sup> Arms or hands (2%)                      <sup>2</sup> Legs or feet (36%)  
<sup>3</sup> Buttocks or Sacrum (58%)                      <sup>4</sup> Other (4%)

**3.6 Is there a treatment plan for this pressure ulcer?**

- <sup>1</sup> Yes (89%)                      <sup>2</sup> No (11%)

**3.7 If the resident has more ulcers, what is the lowest stage pressure ulcer?**

- <sup>1</sup> Stage 1 (13%)                      <sup>2</sup> Stage 2 (12%)                      <sup>3</sup> Stage 3 (2%)  
<sup>4</sup> Stage 4 (2%)                      <sup>5</sup> no other ulcers (71%)

----- If the answer to 3.7 is 5, no other ulcers, then skip to Part 4. -----

**3.8 Is there a treatment plan for this pressure ulcer?**

- <sup>1</sup> Yes (86%)                      <sup>2</sup> No (14%)

**Part 4. Infectious Illnesses**

All questions in this section MUST BE ANSWERED.

**4.1\* Has the resident had a urinary tract infection at any time in the last 7 days?**

- <sup>1</sup> Yes-MRSA (0%)                      <sup>2</sup> Yes-VRE (0.3%)  
<sup>3</sup> Yes-other (4.9%)                      <sup>4</sup> No (94.8%)

**4.2\* Has the resident had a skin or wound infection at any time in the last 7 days?**  
(Responses do not sum to 100% due to rounding)

- <sup>1</sup> Yes-MRSA (0.3%)                      <sup>2</sup> Yes-VRE (0.1%)  
<sup>3</sup> Yes-other (2.8%)                      <sup>4</sup> No (96.8%)

**4.3\* Has the resident had pneumonia at any time in the last 7 days?**

- <sup>1</sup> Yes-MRSA (0.1%)                      <sup>2</sup> Yes-VRE (0%)  
<sup>3</sup> Yes-other (1.7%)                      <sup>4</sup> No (98.2%)

**4.4\* Has the resident had diarrhea AND fever at any time in the last 7 days?**

- <sup>1</sup> Yes-C. dif (0.2%)       <sup>2</sup> Yes-other (0.1%)       <sup>3</sup> No (99.6%)

**4.5\* Has the resident had any other infection at any time in the last 7 days?**

- <sup>1</sup> Yes-MRSA (0%)       <sup>2</sup> Yes-VRE (0%)  
 <sup>3</sup> Yes-other (3.8%)       <sup>4</sup> No (96.1%)

**Part 5. Pain Assessment**

All questions in this section MUST BE ANSWERED.

**5.1\* What is the resident's current level of pain?** Perform the assessment with the Wong-Baker tool provided. (Note: *Unable to determine* means that you cannot determine the resident's level of pain because the resident cannot tell you.)

- <sup>1</sup> no pain (65%)       <sup>2</sup> mild (10%)       <sup>3</sup> moderate (7%)  
 <sup>4</sup> severe (2%)       <sup>5</sup> very severe (1%)       <sup>6</sup> worst (0%)  
 <sup>7</sup>Unable to determine (15%)

**5.2\* According to the last 7 days of documentation in the clinical records, what has the resident's most severe level of pain been?** (Note: *Unable to determine* means that the clinical record does not address the presence or absence of pain.)

- <sup>1</sup> no pain (48%)       <sup>2</sup> mild (6%)       <sup>3</sup> moderate (8%)  
 <sup>4</sup> severe (3%)       <sup>5</sup> very severe (1%)       <sup>6</sup> worst (1%)  
 <sup>7</sup>Unable to determine (33%)

**5.3\* Is an observational pain assessment tool (e.g., PAINAD, DS-DAT (Discomfort Scale for Dementia of the Alzheimer's Type) Pain Scale) being used to assess the resident's pain?**

- <sup>1</sup> Yes (38%)       <sup>2</sup> No (62%)

**5.4\* Is the same assessment tool (used for 5.3) used every time the resident is assessed for pain?** (Answer this item NA if 5.3 is answered NO.)

- <sup>1</sup> Yes (35%)       <sup>2</sup> No (6%)       <sup>8</sup> Not Applicable (59%)

**5.5\* Is a validated self-report pain assessment tool used to assess the resident's pain?** (e.g., Wong-Baker Scale, Pain thermometer, a six-step verbal description scale or a numeric 0-10 rating scale)

- <sup>1</sup> Yes (63%)                       <sup>2</sup> No (37%)

**5.6\* Is the same assessment tool (used for 5.5) used every time the resident is assessed for pain?** (Answer this item NA if 5.5 is answered NO.)

- <sup>1</sup> Yes (57%)                       <sup>2</sup> No (7%)                       <sup>8</sup> Not Applicable (36%)

**5.7\* Is the resident (or family) satisfied with the resident's level of pain relief during the last 24 hours?** (Note: *Unable to determine* means that neither the resident nor family can tell you.)

- <sup>1</sup> Yes (69%)                       <sup>2</sup> No (4%)                       <sup>3</sup> Unable to determine (27%)

**5.8\* How often is pain assessed?**

- |  |   |
|--|---|
| <input type="radio"/> <sup>1</sup> every shift (32%)             | <input type="radio"/> <sup>2</sup> every day (8%)       |
| <input type="radio"/> <sup>3</sup> once a week (4%)              | <input type="radio"/> <sup>4</sup> once a month (12%)   |
| <input type="radio"/> <sup>5</sup> before pain meds (11%)        | <input type="radio"/> <sup>6</sup> after pain meds (3%) |
| <input type="radio"/> <sup>7</sup> no record of assessment (16%) | <input type="radio"/> <sup>8</sup> N/A (no pain) (14%)  |

## **Part 6. Fall Risk Assessment**

Questions 6.1 and 6.2 **MUST BE ANSWERED**. Question 6.3 **MUST BE ANSWERED** when the answer to 6.2 is YES.

**6.1\* Is there evidence that the resident was assessed for fall risks within 14 days of admission or within 14 days of the most recent FULL MDS assessment?** (Use most recent event.)

- <sup>1</sup> Yes (79%)                       <sup>2</sup> No (21%)

**6.2\* Is there evidence that the resident fell in the past 30 days AND was in the facility at some point in the subsequent 24 hours?**

- <sup>1</sup> Yes (7%)                       <sup>2</sup> No (93%)

----- If item 6.2 was answered NO, then skip to Part 7 -----

**6.3 If the resident fell in the last 30 days, is there documentation that the resident was reassessed for fall risks within 24 hours after the fall?**

- <sup>1</sup> Yes (51%)                       <sup>2</sup> No (39%)                       <sup>3</sup> Transferred to ER or Hospital (10%)

## Part 7. Immunizations

All questions in this section MUST BE ANSWERED.

**7.1\* Is there any documentation that the resident has ever received polyvalent (including trivalent) Pneumococcal vaccine?** (Any form of documentation is acceptable.)

- <sup>1</sup> Yes (61%)                       <sup>2</sup> No (39%)

**7.2\* Is there proper documentation of the pneumococcal vaccine that the resident received?** (Look for documentation of Pneumovax or Pneu-Immune or Pneumococcal vaccine. Documentation must be by the entity that actually gave it and must include date, name of vaccine, and signature. "Received at hospital," is not sufficient. The documentation of the event must be from the hospital, clinic or doctor's office itself, and the same data elements must be present.)

- <sup>1</sup> Yes (34%)                       <sup>2</sup> No (66%)

**7.3\* Is there any documentation that Influenza vaccine for the 2007 (August 2007 thru May 2008) Influenza Season was given?** (Any form of documentation is acceptable.)

- <sup>1</sup> Yes (67%)                       <sup>2</sup> No (33%)

**7.4\* Is there proper documentation that Influenza vaccine for the 2007 Influenza Season was given?** (Documentation must be by the entity that actually gave it and must include date, name of vaccine, and signature. "Received at hospital," is not sufficient. The documentation of the event must be from the hospital, clinic or doctor's office itself, and the same data elements must be present.)

- <sup>1</sup> Yes (50%)                       <sup>2</sup> No (50%)

**7.5\* In what month did the resident receive a 2007 Influenza Season Vaccine?** (See documentation requirements in 7.1.) (Responses may not sum to 100% due to rounding)

- |  |  |  |
|--|--|--|
| <input type="radio"/> <sup>1</sup> Aug '07 (0.4%)  | <input type="radio"/> <sup>2</sup> Sep '07 (1.2%)                                | <input type="radio"/> <sup>3</sup> Oct '07 (43.3%) |
| <input type="radio"/> <sup>4</sup> Nov '07 (12.4%) | <input type="radio"/> <sup>5</sup> Dec '07 (2.1%)                                | <input type="radio"/> <sup>6</sup> Jan '08 (1.5%)  |
| <input type="radio"/> <sup>7</sup> Feb '08 (0.8%)  | <input type="radio"/> <sup>8</sup> Mar '08 (0.3%)                                | <input type="radio"/> <sup>9</sup> Apr '08 (0.1%)  |
| <input type="radio"/> <sup>10</sup> May '08 (0%)   | <input type="radio"/> <sup>11</sup> Influenza Vaccine was <u>Not Given</u> (38%) |  |

**7.6\* Is there evidence that the resident is allergic to either eggs or a previous Influenza shot or has had Guillain-Barré syndrome (GBS)?**

- <sup>1</sup> Yes (2%)                       <sup>2</sup> No (98%)

**7.7\* Is there documentation that the resident (or family) REFUSED the Influenza shot?**

- <sup>1</sup> Yes (13%)                       <sup>2</sup> No (87%)

**Part 8. Advance Care Planning**

Questions 8.1 through 8.3 MUST BE ANSWERED. Questions 8.4 through 8.6 MUST BE ANSWERED when the answer to any item from 8.1a-8.1e is YES.

**After a thorough search of the clinical record, which of the following ACP documents did you find?**

- |   |  |   |
|---|--|---|
| <b>8.1a* Out-of-Hospital DNR (OOHDNR)</b>       | <input type="radio"/> <sup>1</sup> Yes (52%) | <input type="radio"/> <sup>2</sup> No (48%) |
| <b>8.1b* Directive to Physicians</b>            | <input type="radio"/> <sup>1</sup> Yes (24%) | <input type="radio"/> <sup>2</sup> No (76%) |
| <b>8.1c* Durable Medical Power of Attorney</b>  | <input type="radio"/> <sup>1</sup> Yes (30%) | <input type="radio"/> <sup>2</sup> No (70%) |
| <b>8.1d* DNR order</b>                          | <input type="radio"/> <sup>1</sup> Yes (42%) | <input type="radio"/> <sup>2</sup> No (58%) |
| <b>8.1e* Other intervention-limiting orders</b> | <input type="radio"/> <sup>1</sup> Yes (8%)  | <input type="radio"/> <sup>2</sup> No (92%) |

**8.2\* According to facility documents, when did the facility staff first discuss advance care planning with the resident or family?**

- <sup>1</sup> Prior to admission (25%)  
 <sup>2</sup> Within 21 days of admission (50%)  
 <sup>3</sup> Within the first 90 days of admission (3%)  
 <sup>4</sup> 90 or more days after admission (11%)  
 <sup>5</sup> Advance Care Planning has not been discussed with the resident or family (11%)

**8.3\* Did the facility staff discuss advance care planning with the resident or family within the 21 days after the most recent full MDS assessment?**

- <sup>1</sup> Yes (59%)                       <sup>2</sup> No (41%)

----- If ALL items 8.1a-8.1e were answered NO, then skip to Part 9 -----

**8.4 On first accessing the chart, were you able to find all of the existing advance directives and care limiting order documents within 30 seconds?**

- <sup>1</sup> Yes (91%)                       <sup>2</sup> No (9%)

**8.5 Is the care being provided consistent with the instructions in the advance care planning documents?**

- <sup>1</sup> Yes (97%)                       <sup>2</sup> No (3%)

**8.6 Does the Advance Care Plan address artificial nutrition and hydration?**

- <sup>1</sup> Yes (24%)                       <sup>2</sup> No (76%)

**Part 9. Tube Feeding**

Question 9.1 MUST BE ANSWERED. Questions 9.2 through 9.7 MUST BE ANSWERED when the answer to 9.1 is YES.

**9.1\* Is the resident receiving tube feedings?** (Includes NG tube, PEG, or other enteral tube providing artificial nutrition and/or hydration)

- <sup>1</sup> Yes (8%)                       <sup>2</sup> No (92%)

----- If item 9.1 was answered NO, then skip to Part 10 -----

**9.2 Is the reason for tube feeding the occurrence of aspiration pneumonia or pressure sores in the context of late-stage dementia (non-verbal, non-ambulatory)?**

- <sup>1</sup> Yes (45%)                       <sup>2</sup> No (55%)

**9.3 Does the resident have late-stage dementia (non-verbal, non-ambulatory) or end-stage illness such as metastatic cancer or organ failure or poor performance status (ECOG performance score 3 or greater) related to advanced cancer?**

- <sup>1</sup> Yes (40%)                       <sup>2</sup> No (60%)

**9.4 Is there evidence that the resident or resident's representative provided informed consent for tube feeding?** (See the Guidance.)

- <sup>1</sup> Yes (32%)                       <sup>2</sup> No (68%)

**9.5 Has tube feeding been provided for more than 30 days?**

- <sup>1</sup> Yes (90%)                       <sup>2</sup> No (10%)

**9.6 If the resident has been receiving tube feeding for more than 30 days, has there been a reassessment of the effectiveness of the feeding tube in the last 30 days?**  
(Reassessment must be based on progress toward specific measurable goals.)

- <sup>1</sup> Yes (53%)                       <sup>2</sup> No (30%)                       <sup>8</sup> Not Applicable (17%)

**9.7 Does the resident have a feeding tube in place that has not been used for more than 30 days for nutrition or hydration?**

- <sup>1</sup> Yes (2%)                       <sup>2</sup> No (86%)                       <sup>8</sup> Not Applicable (12%)

### **Part 10. Nutrition**

Question 10.1 MUST BE ANSWERED.

**10.1\* Is there a comprehensive nutritional assessment completed for the resident?**  
(This may be an initial assessment done on admission or an annual if the resident has been in the facility for a year. You need to review the most recent.)

- <sup>1</sup> Yes (93%)                       <sup>2</sup> No (7%)

----- If item 10.1 was answered NO, then skip to 10.3 -----

**10.2 Does the nutritional assessment include estimating resident nutritional needs?**

- <sup>1</sup> Yes (97%)                       <sup>2</sup> No (3%)

**10.3 Have risk factors for weight loss been identified?**

- <sup>1</sup> Yes (69%)                       <sup>2</sup> No (31%)

**10.4 Have risk factors for the potential of dehydration been identified?**

- <sup>1</sup> Yes (63%)                       <sup>2</sup> No (37%)

### **Part 11. Use of Anti-anxiety Medications**

All questions in this section MUST BE ANSWERED. Each of these questions must be answered independently (For examples, see items 11.3 through 11.5 “If there is no valid anxiety diagnosis...” in the Guidance).

**11.1\* Is there documentation of a psychiatric consultation or a primary care visit that gives a diagnosis of generalized anxiety disorder, panic disorder, social anxiety disorder, agoraphobia, PTSD, or anxiety due to a medical illness that is not Dementia?**

- <sup>1</sup> Yes (16%)                       <sup>2</sup> No (84%)



**11.2\* Is there documentation of one or more anxiety symptoms characteristic of the disorder identified in 11.1?** (If item 11.1 is answered NO, then answer 11.2 Not Applicable. If 11.1 is answered YES, then refer to the symptom list in the guidance.)

- <sup>1</sup> Yes (13%)                       <sup>2</sup> No (12%)                       <sup>8</sup> Not Applicable (75%)

**11.3\* Is there documentation that the resident has been assessed for anxiety symptoms using a Beck Anxiety Inventory or Hamilton Anxiety Scale in the past 6 months?**

- <sup>1</sup> Yes (6%)                       <sup>2</sup> No (94%)

**11.4\* Is there documentation of ongoing anxiety symptom assessment (at least every 2 weeks) for the stated, measurable therapeutic goals of anti-anxiety therapy?** (Responses do not sum to 100% due to rounding)

- <sup>1</sup> Yes (10%)                       <sup>2</sup> No (12%)  
 <sup>8</sup> Not Applicable (i.e., no measurable goals) (79%)

## **Part 12. Use of Hypnotic Medications**

All questions in this section **MUST BE ANSWERED.**

**12.1\* Has the resident complained of sleep problems within the last 14 days?**

- <sup>1</sup> Yes (8%)                       <sup>2</sup> No (92%)

**12.2\* Has the resident had a hospitalization, experienced a sudden loss of physical functioning or independence, experienced the death of a loved one, or had a significant change in personal environment in the last 14 days?** (e.g., a change in personal environment can be new admission to the facility, loss of roommate, new roommate, or conflict with family)

- <sup>1</sup> Yes (9%)                       <sup>2</sup> No (91%)

**12.3\* Do the last 14 days of MAR show an active prescription for sleep problems?**

- <sup>1</sup> Yes (15%)                       <sup>2</sup> No (85%)

**12.4\* Is there evidence that the resident has been evaluated for sleep hygiene including all of the following: diet history, daytime habits, sleeping habits, and sleeping environment?** (Refer to the Guidance for examples.)

- <sup>1</sup> Yes (12%)                       <sup>2</sup> No (88%)

**12.5\* Has the resident's sleep pattern been consistently monitored during the last 14 days?**

- <sup>1</sup> Yes (26%)                       <sup>2</sup> No (74%)

**Part 13. Restraints**

Question 13.1 MUST BE ANSWERED.

**13.1\* Has the person been restrained in the last 30 days?**

- <sup>1</sup> Yes (29%)                       <sup>2</sup> No (63%)                       <sup>3</sup> Unknown (8%)

---- If item 13.1 was answered NO or UNKNOWN, then skip to Part 14 ----

**13.2 What type(s) of restraints were used? (mark all that apply)**

- <sup>1</sup> Mechanical (87%)
- <sup>1a</sup> Full bed rails (58%)
  - <sup>1b</sup> Other types of bed rails (32%)
  - <sup>1c</sup> Trunk restraints (3%)
  - <sup>1d</sup> Limb restraints (1%)
  - <sup>1e</sup> Chair prevention rising (18%)
- <sup>2</sup> Personal (2%)
- <sup>3</sup> Chemical (2%)
- <sup>3a</sup> Topical (0%)
  - <sup>3b</sup> Injectable (0.3%)
  - <sup>3c</sup> Oral (1%)
  - <sup>3d</sup> IV (0%)
  - <sup>3e</sup> Other (0.5%)
- <sup>4</sup> NACES evaluator unable to determine from record (0.3%)

**13.3 If bedrails were used as a restraint device, why were they used? (mark all that apply)**

- <sup>1</sup> To control disruptive behavior (2%)
- <sup>2</sup> To control person from wandering (6%)
- <sup>3</sup> To control from getting up at night (12%)
- <sup>4</sup> Other (58%)
- <sup>5</sup> NACES evaluator unable to determine from record (23%)

**13.4 Did the resident's family or guardian request the use of restraints?**

- <sup>1</sup> Yes (28%)                       <sup>2</sup> No (66%)                       <sup>8</sup> Not Applicable (6%)

**13.5 What alternatives were tried to prevent the use of restraints?** (mark all that apply)

- <sup>1</sup> Verbal de-escalation or redirection (5%)
- <sup>2</sup> Interpersonal physical separation (0%)
- <sup>3</sup> Environmental remediation (5%)
- <sup>4</sup> Other (9%)
- <sup>5</sup> None (23%)
- <sup>6</sup> NACES evaluator unable to determine from record (63%)

**Part 14. Quality of Life / Consumer Satisfaction**

Questions 14.1 & 14.2 MUST BE ANSWERED. If the resident is unable to answer, then a family member or guardian may only answer items 14.26 and 14.27. No other individual may answer for the resident. If ANY question from 14.3 to 14.25 is answered, then EVERY question in this section must be answered.

**14.1\* Who is responding to this survey?**

- <sup>1</sup> Resident (69%)
- <sup>2</sup> Family member or Guardian (10%)
- <sup>3</sup> Neither (21%)

**14.2\* Was a translator used for this survey?**

- <sup>1</sup> Yes (4%)
- <sup>2</sup> No (96%)

-- If 14.1 was answered, "Family member or Guardian" then SKIP to 14.26--

----- If item 14.1 was answered, "Neither" then STOP -----

**14.3 Can you find a place to be alone when you wish?**

- <sup>1</sup> Always (51%)
- <sup>2</sup> Sometimes (20%)
- <sup>3</sup> Rarely (7%)
- <sup>4</sup> Never (13%)
- <sup>5</sup> No Answer (9%)

**14.4 Can you make a private phone call?**

- <sup>1</sup> Always (57%)
- <sup>2</sup> Sometimes (14%)
- <sup>3</sup> Rarely (4%)
- <sup>4</sup> Never (14%)
- <sup>5</sup> No Answer (11%)

**14.5 When you have a visitor, can you find a place to visit in private?** (Responses do not sum to 100% due to rounding)

- <sup>1</sup> Always (55%)
- <sup>2</sup> Sometimes (23%)
- <sup>3</sup> Rarely (5%)
- <sup>4</sup> Never (9%)
- <sup>5</sup> No Answer (9%)

**14.6 Can you be together in private with another resident (other than your roommate)?** (Responses do not sum to 100% due to rounding)

- <sup>1</sup> Always (40%)       <sup>2</sup> Sometimes (21%)       <sup>3</sup> Rarely (7%)  
 <sup>4</sup> Never (16%)       <sup>5</sup> No Answer (17%)

**14.7 Do you participate in religious activities here?**

- <sup>1</sup> Always (32%)       <sup>2</sup> Sometimes (26%)       <sup>3</sup> Rarely (8%)  
 <sup>4</sup> Never (31%)       <sup>5</sup> No Answer (3%)

**14.8 Do the religious observances here have personal meaning for you?**

- <sup>1</sup> Always (39%)       <sup>2</sup> Sometimes (20%)       <sup>3</sup> Rarely (7%)  
 <sup>4</sup> Never (22%)       <sup>5</sup> No Answer (12%)

**14.9 Do you enjoy the organized activities here at the nursing home?**

- <sup>1</sup> Always (31%)       <sup>2</sup> Sometimes (31%)       <sup>3</sup> Rarely (12%)  
 <sup>4</sup> Never (22%)       <sup>5</sup> No Answer (4%)

**14.10 Outside of religious activities, do you have enjoyable things to do at the nursing home during the weekends?**

- <sup>1</sup> Always (13%)       <sup>2</sup> Sometimes (23%)       <sup>3</sup> Rarely (22%)  
 <sup>4</sup> Never (31%)       <sup>5</sup> No Answer (11%)

**14.11 Do you like the food here?**

- <sup>1</sup> Always (41%)       <sup>2</sup> Sometimes (41%)       <sup>3</sup> Rarely (9%)  
 <sup>4</sup> Never (7%)       <sup>5</sup> No Answer (2%)

**14.12 Do you enjoy mealtimes here?** (Responses may not sum to 100% due to rounding)

- <sup>1</sup> Always (53%)       <sup>2</sup> Sometimes (30%)       <sup>3</sup> Rarely (7%)  
 <sup>4</sup> Never (6%)       <sup>5</sup> No Answer (5%)

**14.13 Can you get your favorite foods here?**

- <sup>1</sup> Always (25%)       <sup>2</sup> Sometimes (35%)       <sup>3</sup> Rarely (15%)  
 <sup>4</sup> Never (14%)       <sup>5</sup> No Answer (11%)

**14.14 Do you feel that your possessions are safe at this nursing home?**

- <sup>1</sup> Always (65%)       <sup>2</sup> Sometimes (19%)       <sup>3</sup> Rarely (4%)  
 <sup>4</sup> Never (6%)       <sup>5</sup> No Answer (6%)

**14.15 Have your clothes gotten lost or damaged in the laundry in the last month?**

- <sup>1</sup> Always (10%)       <sup>2</sup> Sometimes (22%)       <sup>3</sup> Rarely (11%)  
 <sup>4</sup> Never (45%)       <sup>5</sup> No Answer (12%)

**14.16 Do you feel safe and secure?**

- <sup>1</sup> Always (84%)       <sup>2</sup> Sometimes (11%)       <sup>3</sup> Rarely (1%)  
 <sup>4</sup> Never (1%)       <sup>5</sup> No Answer (3%)

----- If item 14.16 was answered YES, then skip to 14.18 -----

**14.17 Do you feel unsafe and insecure because of? (mark all that apply)**

- <sup>1</sup> Direct Care Staff (33%)       <sup>2</sup> Non Care Staff (13%)  
 <sup>3</sup> Other Residents (29%)       <sup>4</sup> Environmental Concerns (12%)  
 <sup>5</sup> Other (34%)

**14.18 Do you ever have concerns that the facility does not address?**

- <sup>1</sup> Yes (13%)       <sup>2</sup> No (87%)

**14.19 Have you heard of the Ombudsman Program?**

- <sup>1</sup> Yes (16%)       <sup>2</sup> No (84%)

**14.20 Do you know how to contact an Ombudsman?**

- <sup>1</sup> Yes (7%)       <sup>2</sup> No (93%)

**14.21 Have you used the services of an Ombudsman in the last 12 months?**

- <sup>1</sup> Yes (2%)       <sup>2</sup> No (98%)

----- If item 14.21 was answered YES, then skip to 14.25 -----

**14.22 How helpful has your Ombudsman been to you?**

- <sup>1</sup> Not helpful (40%)       <sup>2</sup> Neutral (53%)       <sup>3</sup> Very helpful (7%)

**14.23 In the last month, have you had a concern that you did not express because you were afraid of retaliation?**

- <sup>1</sup> Yes (5%)                       <sup>2</sup> No (95%)                       <sup>3</sup> Don't Know (0%)

**14.24 Have you been given a choice of hospice care?**

- <sup>1</sup> Yes (10%)                       <sup>2</sup> No (37%)                       <sup>3</sup> Don't Know (53%)

**14.25 Does your facility offer a variety of hospice agency providers from which to choose?**

- <sup>1</sup> Yes (8%)                       <sup>2</sup> No (9%)                       <sup>3</sup> Don't Know (83%)

**14.26 Overall, how satisfied are you with your (your family member's) experience in this nursing facility?**

- <sup>1</sup> Very Dissatisfied (3%)                       <sup>2</sup> Dissatisfied (2%)  
 <sup>3</sup> Somewhat Dissatisfied (4%)                       <sup>4</sup> Neither (2%)  
 <sup>5</sup> Somewhat Satisfied (14%)                       <sup>6</sup> Satisfied (44%)  
 <sup>7</sup> Very Satisfied (31%)                       <sup>8</sup> Not applicable (0%)

**14.27 Overall, how satisfied are you (your family member's) with your health care services?**

- <sup>1</sup> Very Dissatisfied (3%)                       <sup>2</sup> Dissatisfied (3%)  
 <sup>3</sup> Somewhat Dissatisfied (4%)                       <sup>4</sup> Neither (2%)  
 <sup>5</sup> Somewhat Satisfied (11%)                       <sup>6</sup> Satisfied (46%)  
 <sup>7</sup> Very Satisfied (30%)                       <sup>8</sup> Not applicable (1%)

I certify by my signature below that the *DADS ID* number of the resident has been doubled-checked for accuracy, and that the information in this document is an accurate assessment of the resident.

**QR Nurse Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Appendix B – Acronyms**

AAA	Area Agencies on Aging
ACE	Angiotensin converting enzyme
ADD	Assessment of Discomfort in Dementia
ATW	Aging Texas Well
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid
CNA	Certified Nursing Assistant
CPR	Cardiopulmonary Resuscitation
DADS	Department of Aging and Disability Services
DNR	Do-Not-Resuscitate
ECOG	Easter Cooperative Oncology Group
FDA	Food and Drug Administration
HHSC	Health and Human Services Commission
LTC	Long-term care
LTSS	Long-term services and supports
MAR	Medication Administration Record
MDS	Minimum Data Set
MRSA	Methicillin Resistant Staphylococcus Aureus
NACES	Nurse Aide Competency Evaluation Service Plus Foundation, Inc
NFQR	Nursing Facility Quality Review
NHQIC	Nursing Home Quality Improvement Coalition
NPUAP	National Pressure Ulcer Advisory Panel
NSAID	Nonsteroidal anti-inflammatory drug
OBRA	Omnibus Budget Reconciliation Act
PAINAD	Pain Assessment in Advanced Dementia
PEG	Percutaneous Endoscopic Gastrostomy
QAI	Quality Assurance and Improvement
QMP	Quality Monitoring Program
QOL	Quality of Life
T4A	Texas Association of Area Agencies on Aging
TFPC	Texas Falls Prevention Coalition
VRE	Vancomycin Resistant Enterococcus

