Nursing Facility Quality Review 2007

Center for Policy and Innovation
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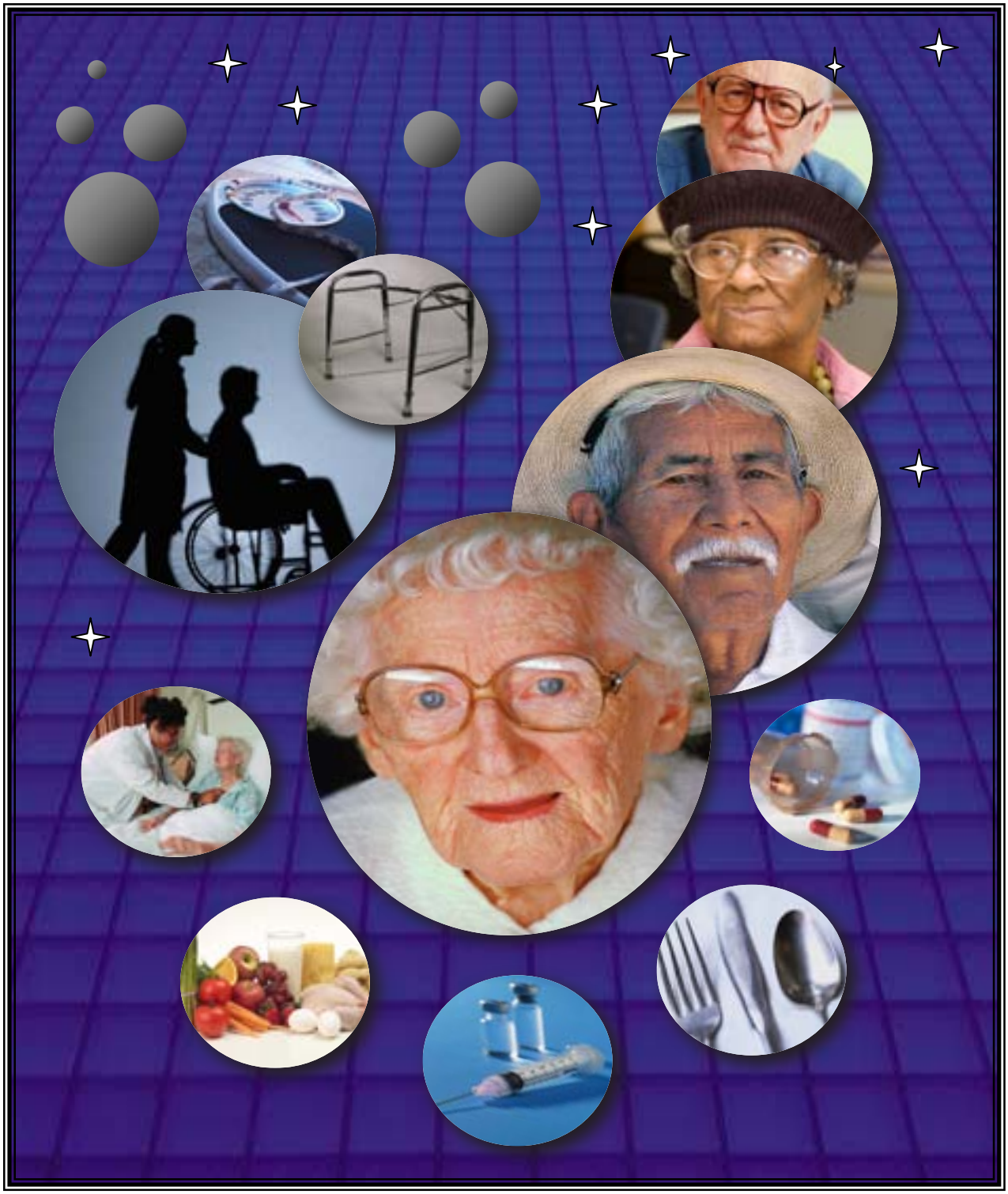

2007 Nursing Facility Quality Review

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

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Preface

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 of their care. DADS contracted with the Nurse Aid Competency Evaluation Services (NACES) Plus Foundation, Inc. to perform on-site assessments and surveys of residents in nursing facilities in order to identify preventable occurrences of adverse outcomes.

The Nursing Facility Quality Review (NFQR) includes the results of interviews and examinations on a random sample of residents in nursing facilities across the state. In addition, Minimum Data Set (MDS) Resident Assessment Instrument data recorded by the nursing facility was compared to survey data. Analysis of the data allows DADS to assess resident quality of care and quality of life and formulate interventions throughout DADS programs to continuously improve outcomes.

1.0 Executive Summary

The Nursing Facility Quality Review (NFQR) is a statewide process used by the Texas Department of Aging and Disability Services (DADS) to benchmark the quality of care and the quality of life for residents in Texas nursing facilities.

- Of the 118,882 people (including those with Medicare, Medicaid, or any other payer source) living in the 1,045 Medicaid certified nursing facilities in Texas, a subset of 2,031 residents were randomly selected, assessed, and interviewed.

This report documents the results for calendar year 2007, and includes comparative and trend data which is used in decision-making to continuously improve outcomes for residents of nursing facilities in Texas.

1.1 Key Findings

Texas nursing facilities show noted improvements in:

- Reliability and consistency of pain assessments;
- Nutritional reassessments for people receiving tube feedings;
- Less use of indwelling bladder catheters; and
- Improved prescribing practices for antipsychotic drugs.

However, the results indicate static numbers for the proportions of residents who:

- Experience incontinence;
- Are prescribed antipsychotic medications;
- Accept vaccination against influenza; and
- Use the Durable Medical Power of Attorney document.

Areas in which declines are noted or which need improvement are:

- Worsening level of reported pain;
- Pain control;
- Greater resident privacy and activity options; and
- Resolving reported sleep problems.

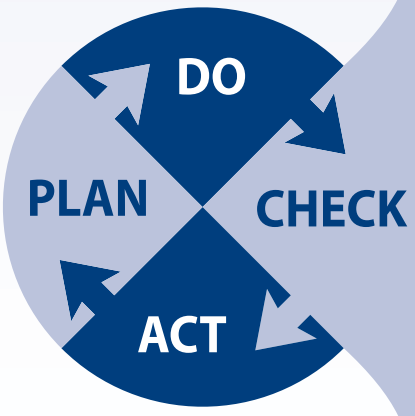
Survey results indicate that 75% of residents are “satisfied” to “very satisfied” with their overall experience in the nursing facility.

TEXAS Department of Aging and Disability Services

Nursing Facility Quality Review
2007 Findings

Figure 1.1 – Quality of Care & Quality of Life Key Findings

Quality Improvement Process



Notable improvements

- Reliable and consistent pain assessments
- Nutritional reassessments for people on tube feedings
- Less use of indwelling bladder catheters
- Improved prescribing practices for antipsychotic drugs

Static areas

- Number of residents who are incontinent
- Number of residents prescribed antipsychotic drugs
- Residents who accept the flu shot
- Use of the Durable Medical Power of Attorney document

Noted declines or needed improvements

- Worsening level of reported pain
- Pain control
- Resident privacy and activity options
- Problems sleeping despite medications for sleep

Survey conducted: February – July 2007
Survey sample: 2,031 from 118,882 residents (Medicare, Medicaid, or any other payer source) living in the 1,045 Medicaid certified nursing facilities in Texas.

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1.2 Improving Resident Quality of Care and Quality of Life

The findings are used to identify areas where progress has occurred and areas in which changes are needed in Texas nursing facilities. Change plans are then formulated to optimize medical outcomes and day-to-day factors which affect an individual's sense of well-being.

DADS is affecting change internally, through existing programs, and externally with community stakeholders. Internal improvements will be based on the application of evidence-based best medical practices and will leverage DADS' activities in the:

- Quality Monitoring Program for nursing facilities in the disciplines of nursing, pharmacology, and nutrition;
- Advance Care Planning Work Group;
- Statewide Long-Term Care Ombudsman Program;
- Texas Fall Prevention Coalition; and
- Aging Texas Well.

In addition, DADS collaborates with coalitions involving leadership from nursing facilities and statewide aging support networks to further impact the health care delivery system.

Future surveys are being designed to measure progress on the instituted changes and explore new survey areas, such as the prevention of pressure ulcers, the use of inappropriate restraints, the identification of specific areas of resident concern, and to elicit the residents' assessment on their quality of care.

Continuous improvements in quality of life and quality of care for residents in Texas nursing facilities is part of the DADS vision to promote well-being, dignity, and personal choice.

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2.0 Methods

2.1 Review Instrument

The 2007 Nursing Facility Quality Review (NFQR) assessment instrument is a multi-part questionnaire used by the Nurse Aid Competency Evaluation Services (NACES) Plus Foundation, Inc. team contracted by DADS. This assessment tool is used to solicit data directly from the resident or their representative, the resident's medical chart, and the resident's medication administration records. The tool has been in use for several years and is divided into twelve sections covering each of the major topic areas. The tool was modified from the previous year's version to include additional survey questions which:

- Compare a resident's pain severity, location, and symptoms with the Centers for Medicare and Medicaid (CMS) Minimum Data Set (MDS) data reported for that specific resident;
- Assess if feeding tubes in place longer than 30 days continue to be used; and
- Include a new section on nutrition.

A copy of the 2007 assessment instrument is included as Appendix A.

2.2 Methodology

The survey and assessment are based on a randomly selected subset of residents drawn from the total of 118,882 residents in nursing facilities in Texas. The subset was drawn using a proportional sampling strategy from the residents who had an MDS assessment during the period September 1, 2006 to December 31, 2006. The number of residents assessed in 2007 was 2,031. The survey was conducted from February through July 2007.

2.3 Data Collection

DADS contracted with the NACES Plus Foundation, Inc. to perform the on-site assessments and surveys of residents in nursing facilities. Some of the assessment and survey process included correlation of data from MDS assessments. NACES provided the collected data to DADS for analysis.

2.4 Data Analysis

Quantitative data results for 2007 are derived directly from the assessment instrument responses, which are included in Appendix A. During the analysis, some calculations were made on the data using combinations of responses. For example, if a question was applicable to only a subset of the population (persons with bladder catheters) and a separate question determined if pressure ulcers were present, a combined response would determine how many people with a bladder catheter also had a pressure ulcer.

While the assessment tool remained fairly static between 2006 and 2007, new staff analyzed the data which is presented herein. In order to compare this year's data to previous years' data in a consistent manner, the same 2007 analysis process was applied to previous years' data.

3.0 Findings

This section provides the findings of the quality of care and quality of life survey conducted with residents of Texas nursing facilities from February through July 2007.

Of interest:

- At least one resident from each of the 1,045 nursing facilities was interviewed; and
- Nearly half (49%) of the residents report living in the same facility for more than two years.

Subsections 3.1 through 3.11 detail the findings on quality of care and cover the following major topic areas:

- Urinary continence promotion;
- Indwelling bladder catheter;
- Fall risk management;
- Pain assessment and management;
- Immunizations;
- Advance care planning;
- Nutrition, hydration, and unintended weight loss;
- Artificial nutrition and hydration;
- Infectious illnesses;
- Safety of long term care prescribing practices; and
- Psychoactive medication usage.

Subsection 3.12 details the findings on quality of life and overall resident satisfaction in the nursing facility. The areas of quality of life include assessments on:

- Dining, the quality of the meals as well as the enjoyment of mealtimes;
- Activities, including organized, religious, and free-time activities;
- Socialization and privacy; and
- Safety and security of oneself and possessions.

3.1 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, a reluctance to seek help, and can lead to social isolation and depression (Cholhan, 2007). Hence, promoting urinary continence provides both medical and psychosocial benefits.

Proportion with Urinary Incontinence
When Nurse Aid Competency Evaluation Services (NACES) nurses checked the current urinary continence status of residents in nursing facilities, the results for Texas (figure 3.1) indicate:

- 43% of the residents were observed to be wet in 2007. Compared to previous years' reviews, the trend is fairly static:

2004	2005	2006	2007
40%	42%	40%	43%

Reasons for Incontinence
There are many reasons why a person may have urinary incontinence. Some of the reasons are medically related for which incontinence cannot be prevented, such as a terminal condition or a temporary urinary tract infection. Older people are often incontinent because there is either no plan or an ineffective plan in place which reminds them to go or directs staff to take them to go to the bathroom. In some cases, residents prefer to be incontinent rather than have a urinary catheter.

- Of the people with urinary incontinence (43%), reasons found in this year's review and compared to previous years' results are:

Reason for Urinary Incontinence	2004	2005	2006	2007
Have precluding medical condition	7%	11%	7%	8%
Have a plan for urinary continence	18%	15%	8%	12%
Have no plan for urinary continence	67%	71%	73%	73%
Resident refuses to use the bathroom	9%	4%	12%	8%

This data indicates that for people who are incontinent, plans to promote urinary continence are needed.

Effective Urinary Continence Promotion
While some cases of urinary incontinence may benefit from medical testing to evaluate and treat root causes, others would benefit from an individualized continence plan (Agency for Health Care Policy and Research, 2007).

- Of the 12% of residents with urinary incontinence who have a continence promotion plan, the plan is effective for 3% of those individuals.

The findings indicate the current continence promotion approaches are not working effectively. Nursing facility staff members need renewed training to implement individualized continence promotion plans. Residents in nursing facilities need continence promotion plans that work to give them the dignity of urinary continence wherever possible, and prevent medical and social complications that can arise from urinary incontinence.

Urinary Incontinence and Pressure Ulcers
Residents who have urinary incontinence were also examined for evidence of pressure ulcers (i.e., commonly called "bed sores"):

- 2% of residents who have urinary incontinence also have deep pressure ulcers, which are at risk for infection if exposed to urine. Compared to previous years:

2004	2005	2006	2007
2%	2%	2%	2%

This trend indicates that people with urinary incontinence generally do not have pressure ulcers.

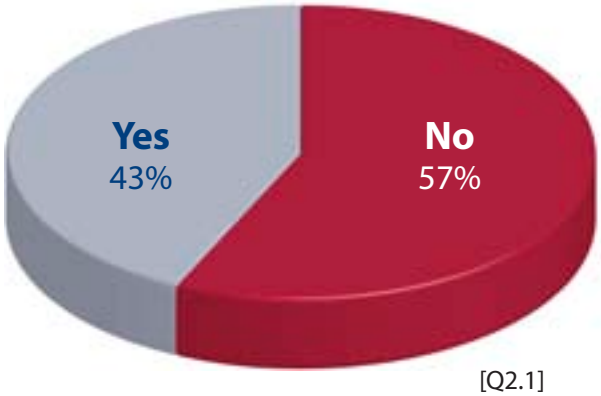
Urinary Continence Status compared to the Minimum Data Set
In addition, NACES compared residents' urinary continence status against that reported in the Minimum Data Set (MDS), which is reported to the Centers for Medicare and Medicaid Services (CMS). Eighty-nine percent of the residents' urinary continence status is accurately reflected in the MDS. As this was the first year the question was asked there is no comparative data.

Bottom Line
People with urinary incontinence need continence promotion plans that work. Continence promotion plans that are known to work are individualized plans.

Figure 3.1 – Urinary Incontinence

Evidence of Urinary Incontinence?

Was there evidence of urinary incontinence?



[Q2.1]

- The survey team was asked to determine if they saw, smelled, or felt evidence of urinary incontinence. 43% answered this question "yes" and 57% answered "no" [Q2.1].
- From other survey questions we know that:
  - 25% of residents are always continent and do not need a continence plan [Q2.8].
  - 2% of residents are unresponsive (i.e., comatose, semi-comatose, stuporous, persistent vegetative state, unarousable, etc.) and not expected to be continent [Q2.2].
  - 89% of data reported into the Minimum Data Set accurately reflects the resident's urinary continence status [Q2.13].

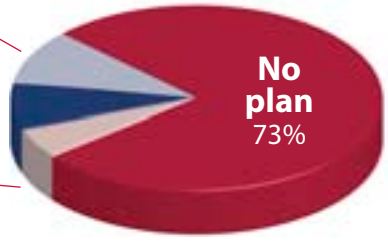
Of those incontinent (43%)

Do they have a continence plan [Q2.6]?

12% Yes, have a continence plan

8% Precluded from toileting [Q2.5]

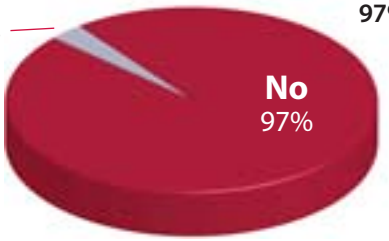
8% Resident refuses toileting [Q2.12]



Of those incontinent who have a plan

Is their continence plan working [Q2.9]?

3% Yes



97% Have had two or more episodes of urinary incontinence in the past two weeks, with most (65%) occurring during normal waking hours [Q2.10].

Of those incontinent (43%)

Do they also have pressure ulcers [Q2.11]?

2% Have deep sores* that could become infected from the urine and cause medical complications

*(Stage III & IV pressure ulcers)

Survey conducted: February – July 2007 **[Q#.#]** = Survey question number
Survey sample: 2,031 from 118,882 residents (Medicare, Medicaid, or any other payer source) living in the 1,045 Medicaid certified nursing facilities in Texas.

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3.2 Indwelling Bladder Catheter Use

Indwelling bladder catheters, a conduit placed in the urinary bladder in order to provide continuous urinary drainage, are used for a variety of reasons:

- To accurately record urine output;
- To complete a specific diagnostic evaluation;
- To administer a prescribed medication;
- To overcome an obstruction in the urinary outflow tract;
- To compensate for ineffective bladder contractions; or
- To prevent urine leakage into serious pressure ulcers.

Proportion with an Indwelling Bladder Catheter
The 2007 survey results (figure 3.2) indicate:

- 4% of residents in nursing facilities have an indwelling bladder catheter. Compared to previous years' reviews:

2004	2005	2006	2007
6%	6%	5%	4%

Documented Medical Reason for Catheter Placement

- Of all those with a catheter (4%), 50% have a documented medical reason for its initial placement and use. Compared to previous years:

2004	2005	2006	2007
72%	57%	50%	50%

This trend indicates a continuing need to ensure the use of indwelling bladder catheters is medically-based.

Catheters and Pressure Ulcers
Prevention strategies are critical to prevent the development of pressure ulcers in the high-risk group of people with indwelling bladder catheters who are confined to bed. Pressure ulcers are staged one through four, with stage one the least serious and characterized by local skin redness and irritation, and stage four the most serious and characterized as extending into deep muscle tissues and/or bone. The etiology of pressure ulcers involves many factors including turning frequency, nutritional status, and prevention strategies to resolve less serious ulcers (stages one and two) before they progress into more serious ones (stages three and four).

- 19% of residents with an indwelling bladder catheter also have at least one stage 3 or stage 4 pressure ulcer. Compared to previous years:

2004	2005	2006	2007
16%	19%	13%	19%

This trend indicates a fairly static level of residents with urinary catheters who also have deep pressure sores, which were either one of the indications for initial catheter placement or which developed after the catheter was placed.

Documented Medical Reason for Chronic Catheter Use
Residents with chronic (in-place for more then six weeks) indwelling bladder catheters also have an increased risk for urinary tract infections, systemic infections, and death (Holroyd-Leduc, 2007).

- Of those who have a bladder catheter in place for more than 6 weeks, 37% have a documented medical reason for its extended use. Compared to previous years:

2004	2005	2006	2007
27%	45%	27%	37%

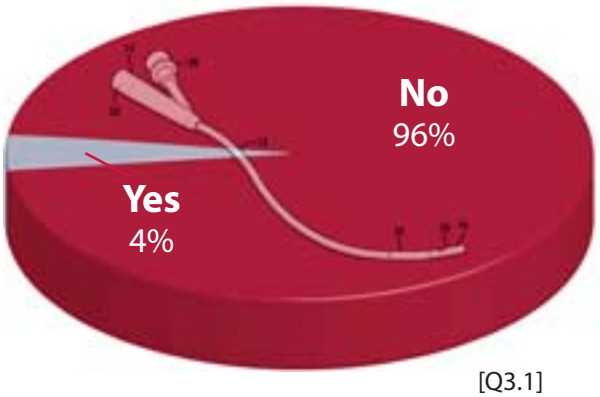
This trend indicates chronic catheter usage continues to need documented medical rationale.

Bottom Line
The number of residents with indwelling bladder catheters has declined to very low levels. Residents with urinary catheters are known to be high risk for pressure ulcers and need documented periodic evaluation to determine if continued catheter usage is truly needed.

Figure 3.2 – Indwelling bladder catheters

Indwelling bladder catheter in place?

Does the resident have an indwelling bladder catheter?



[Q3.1]

- Residents with an indwelling bladder catheter inserted either through the urethra (Foley catheter) or through the abdominal wall (suprapubic catheter).
- Of the 4% of residents with a catheter:
  - 84% have had one in place for more than 6 weeks [Q3.2], indicating chronic use.
  - 7% were prescribed by physicians to accurately record urine output [Q3.3].
  - 1% have a catheter to perform a diagnostic test [Q3.4].

Medically Proven Need?

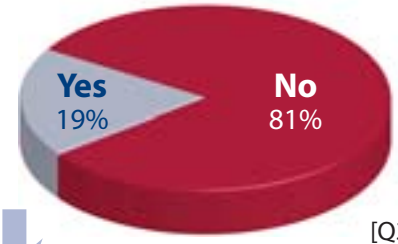
50% Yes

The medical record contains a documented need for its initial placement and use.

[Q3.3 and 3.9]

If they have a catheter (4%)

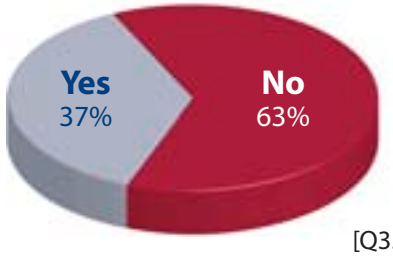
Do they also have a serious (i.e., stage 3 or 4) pressure ulcer?



[Q3.9]

For those with catheter > 6 weeks

Do they have an indication for chronic usage?



[Q3.7 – 3.9]

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3.3 Fall Risk Management Practices

Whether or not a person falls is a combination of health and environmental factors. The fall rate of people in nursing facilities has run as high as 60% in the United States (Fuller, 2000). Risk factors include advancing age, medication usage, cognitive impairment, and sensory defects (e.g., hearing loss, balance impairment). A fall can result in minor injuries, such as contusions or lacerations, to major injuries, such as fractures or strokes, which may require long hospital stays and rehabilitation. Some falls can result in death. Trauma is the fifth leading cause of death, and falls, as a subcategory of trauma, account for 70 percent of accidental deaths in people over the age of 75.

Fall and Fracture Rates
Residents in Texas nursing facilities currently, according to the Minimum Data Set (MDS), have a 10.8% annual fall rate and the bone fracture rate is 1.3% (2007). The MDS does not correlate if a fracture is a direct result of a fall.

- During the survey period, 8% of residents in nursing facilities were recorded to have had a fall in the prior 30 days. Compared to previous years, the fall rate trend has remained fairly static:

2004	2005	2006	2007
9%	10%	8%	8%

Reassessment After a Fall

- This year when a resident fell in a nursing facility, 46% were reassessed for fall risks within 24 hours after their fall to determine if contributing factors had been resolved. Compared to previous years:

2004	2005	2006	2007
30%	47%	35%	46%

While this is an overall upward trend, the findings still indicate that closer follow-up after a fall is needed to ensure all contributing factors (e.g., pharmacological, environmental) are understood and mitigated, if possible, to prevent future falls.

Preventing Falls: The Fall Risk Assessment
While some falls are inevitable, other falls can and should be prevented. The traditional approach to fall reduction includes education, exercise, medication review, and reduction of fall hazards.

- Representing a statistically significant* improvement from last year, 64% of all residents are assessed for fall risk either upon admission into the nursing facility or annually (figure 3.3). Compared to previous years:

2004	2005	2006	2007
60%	65%	58%	64%

This trend indicates continued proactive efforts are needed to prevent falls, which will ultimately reduce fractures and other injuries related to a fall.

The Centers for Disease Control (CDC) reports ten percent of adults over the age of 50 have osteoporosis, and health costs attributed to osteoporotic fractures were estimated at $12 -$18 billion annually (CDC Improving the Clinical Use of Biochemical Bone Marker in Metabolic Disease, CDC Fall Prevention Activities). Recent medical study indicates new findings that Vitamin D reduces the risk of fall and fracture (Jackson, 2007).

- Vitamin D usage in residents of nursing facilities has declined:

2005	2006	2007
26%	27%	22%

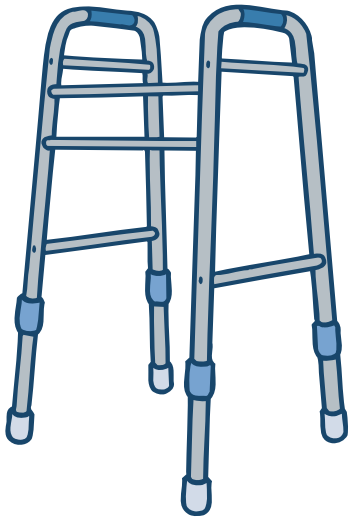
Bottom Line
Fall reduction can prevent suffering and reduce health costs. Initial, annual, or event-driven fall assessments rates could be improved. Osteoporosis prevention, nutritional, and physical therapy strategies to reduce the fall and fracture rate should be considered.

* Statistically significant means unlikely to have occurred by chance and uses a p value of <.01, signifying a 99% chance of being true.

Figure 3.3 – Fall Risk Management

Fall Risk

- Older people have decreased bone densities and therefore more prone to fracture if they fall.*
- Fall prevention strategies can reduce suffering and save health dollars.*
- The annual fall rate in Texas nursing facilities is 10.8%.+

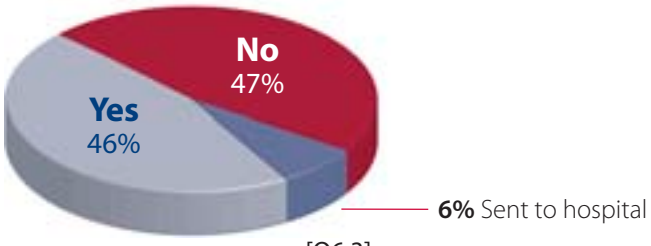


*Centers for Disease Control (www.cdc.gov/nceh/dls/osteoporosis.htm)

+ Minimum Data Set

Of residents who fell in the past 30 days

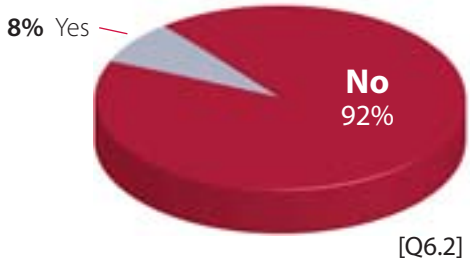
Was a fall assessment done within 24 hours of the fall?



[Q6.3]

For current residents in nursing facilities

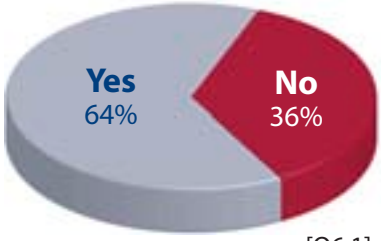
Has there been a fall in the past 30 days?



[Q6.2]

For residents admitted to nursing facility

Was fall risk assessed within 14 days of admission?



[Q6.1]

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3.4 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 Nursing Facility Quality Review (NFQR) survey has been designed to more closely examine pain assessment and pain control for residents in nursing facilities. Two key elements of a successful pain assessment are to use standardized pain assessment tools and then to use the appropriate tool consistently with an individual resident.

Use of Pain Assessment Tools
The NACES surveyors were asked to find evidence in the medical chart that a standardized pain assessment tool is in use. The pain assessment tools include the use of observational tools: the Pain Assessment In Advanced Dementia (PAINAD), the Assessment of Discomfort in Dementia (ADD), or the Abbey Pain Scale; or validated self-reported pain assessment tools: the Wong-Baker scale, a Pain thermometer, a six-step verbal description, or a numeric 0-10 rating scale.

- A standard pain assessment tool is being used 71% of the time (figure 3.4). Compared to previous years:

2004	2005	2006	2007
56%	59%	40%	71%

This trend indicates a statistically significant improvement in the use of standardized pain tools and is felt to represent overall increased awareness in the value of these tools.

Consistency of Pain Assessment Tools
Since use of a consistent pain assessment tool with a resident increases the reliability of the pain assessment, surveyors looked for evidence of consistency in the medical chart.

- 64% of the time, a consistent pain assessment tool is used with a specific resident. Compared to previous years:

2004	2005	2006	2007
42%	39%	35%	64%

These numbers indicate a standardized pain assessment tool is used consistently with a specific resident, hence improving the reliability of the pain assessment. This trend represents a significant improvement in the reliability of the pain assessment data.

Reliable Pain Assessment Results
Improved reliability of pain assessments increases the validity of the resultant responses. Residents were asked to identify their current level of pain.

- The proportion of residents who rated their pain "moderate pain" to "worst pain" using the Wong-Baker scale is 10% in 2007. Compared to previous years:

2004	2005	2006	2007
7%	7%	9%	10%

It is concerning to note that 10% of residents report they are in such a high degree of pain. While this trend indicates an increasing number, it is believed to reflect a more accurate number than in years past because of the improved reliability of the pain assessment.

Pain Control

- Of those in "moderate pain" to "severe pain" 60% report satisfaction with their pain treatment, a decrease since last year:

2004	2005	2006	2007
64%	55%	63%	60%

The trend indicates the need for improved pain control.

Comparative MDS Data
The NACES staff compared the residents' pain symptoms, pain severity, and pain location to that which is recorded in the Minimum Data Set (MDS).

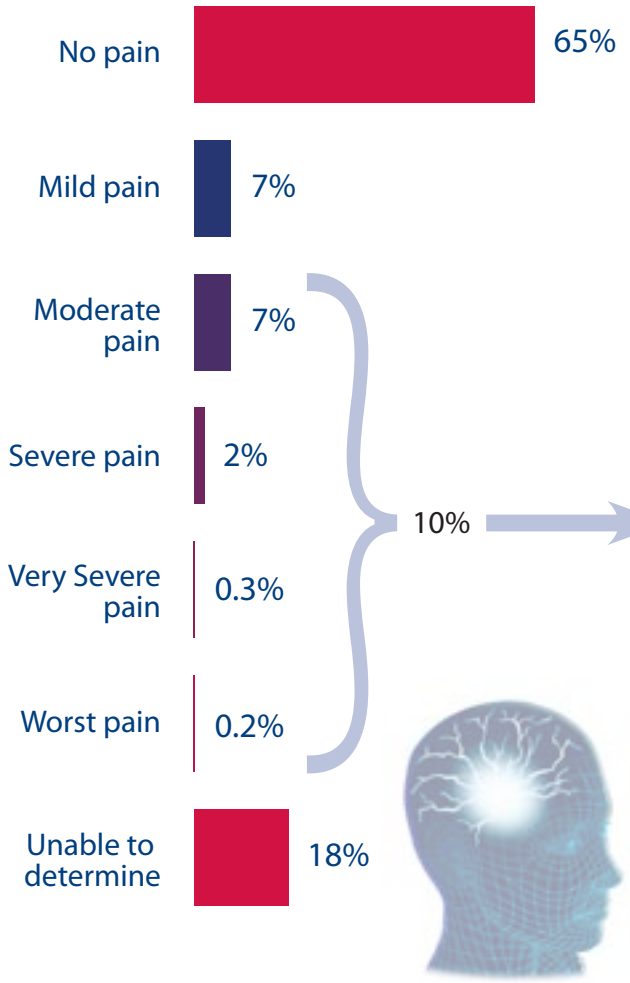
- Generally, pain symptoms, severity, and location are recorded accurately (91%, 84%, 76%, respectively) in the MDS.

As this was new data for 2007, there is no previous comparative data.

Bottom Line
While great strides have been made in obtaining reliable pain assessments, some residents are in significant pain that is not well controlled and in need of more effective treatment.

Figure 3.4 – Pain Assessment and Control

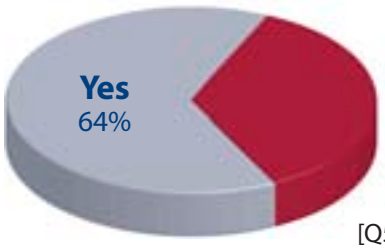
What is the resident's level of pain on the Wong-Baker pain scale* [Q5.1]?



*Wong-Baker is a 0-5 scale used for people to communicate how much pain they are feeling.

Reliability of pain assessment

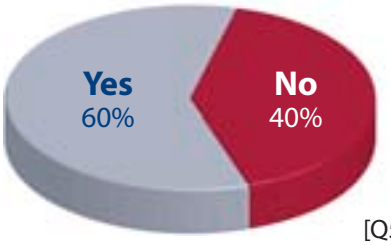
Is a validated pain assessment tool used consistently with a specific resident?



[Q5.3 – 5.6]

Of residents in moderate or worse pain (10%)

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



[Q5.7]

Is pain being reported accurately?*

- Pain intensity correct [Q5.9]: **84% yes; 16% no**
- Location accurate [Q5.10]: **76% yes; 24% no**
- Pain symptoms accurate [Q5.8]: **91% yes; 9% no**

*Into Minimum Data Set (MDS)

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Quality Assurance & Improvement

3.5 Immunization Practices

Healthy People 2010 is a set of health objectives for the nation to achieve this decade. It is a framework for prevention sponsored by the federal government to advance health, consists of 400 national membership organizations, and is supported by all state and territorial health departments. The Healthy People 2010 objective for pneumococcal and influenza vaccinations of residents in nursing facilities is set at 90% (Crutchfield, 2005). Influenza can debilitate a person, leading to an infection of pneumonia. The combination of influenza and pneumonia is the fifth leading cause of death in people age 65 or older.

Influenza Vaccinations

- The rate of annual resident vaccination to prevent influenza (i.e., the flu shot) slightly decreased in 2007 to 75% (figure 3.5):

2004	2005	2006	2007
59%	62%	76%	75%

For the persons not vaccinated, 10% had contraindications to the vaccine or refused the vaccine; however, 15% had no contraindication and did not refuse, and are therefore potentially eligible for vaccination.

Pneumococcal Vaccinations

The pneumococcal vaccination is usually administered to elderly persons once after age 65. Efforts have been ongoing in the state to continue to vaccinate all eligible seniors in nursing facilities in order to reduce the occurrence of bacterial pneumonia.

- The vaccination to prevent pneumococcal pneumonia continues to climb, as expected with a (usually) once in a lifetime vaccine, with a 67% overall vaccination rate:

2004	2005	2006	2007
27%	40%	59%	67%

Comparative MDS Data

The resident's influenza and pneumococcal vaccination status was compared to that recorded in the MDS. Results indicate the MDS accurately reflects the vaccination status 81% of the time for influenza vaccination and 78% of the time for the pneumococcal vaccination. As this was a new comparison done in 2007 there is no previous comparative data.

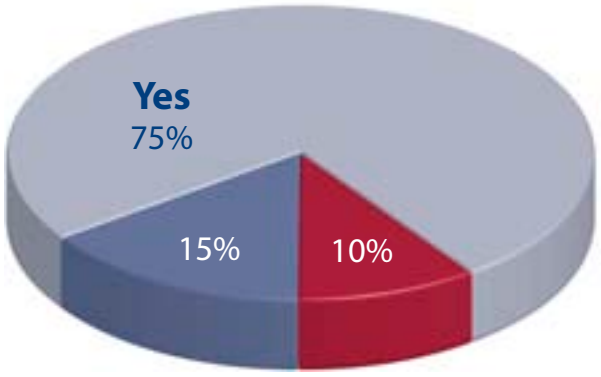
Bottom Line

Many efforts to achieve higher vaccination rates are made in the health community. Immunizations in the elderly, unlike school-age vaccinations, are optional and a personal health choice made by the individual resident in a nursing facility or their representative.

Figure 3.5 – Immunizations

Annual Flu vaccine

Any documentation of yearly flu vaccine given?



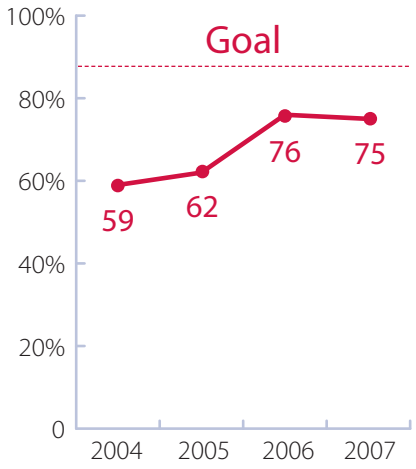
Not vaccinated:
Have no contraindication and did not refuse

Not vaccinated:
Refused or have a contraindication

[Q7.3, 7.6 and 7.7]

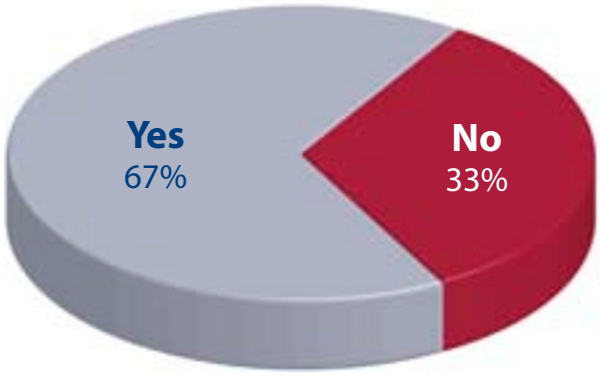
Flu vaccine trends

Annual Flu Vaccination



Pneumonia vaccine (after age 65)

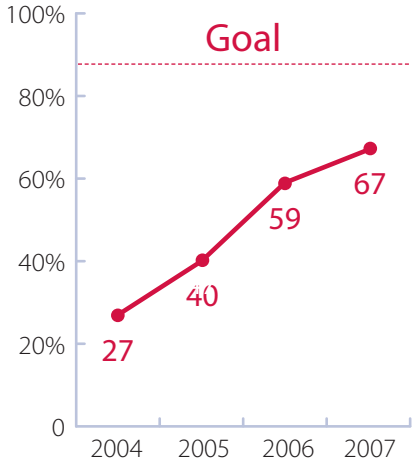
Any documentation of pneumococcal vaccination ever given?



[Q7.1]

Pneumococcal vaccine trends

Pneumococcal Vaccination



*one shot after age 65

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Quality Assurance & Improvement

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3.6 Advance Care Planning

Advance care planning is a way of documenting an individual's personal choice for health care in advance of a medical event which precludes them from expressing their wishes in medical decision-making. The type of care choices that are generally employed are:

- Heroic measures: Do everything, including cardiac defibrillation (i.e., electric shocks to the heart), ventilation for respiration, and administer medications; or
- Limited heroic measures: Cardiopulmonary resuscitation (CPR) and medicines are allowed, but no cardiac defibrillation or ventilator; or
- Palliative care: Usually combined with a Do Not Resuscitate (DNR) order and provides comfort measures only.

Proportion with Advance Care Document

- Of residents in nursing facilities, 66% have an advance care directive which outlines the type of care they wish to receive in the event of a medical emergency (figure 3.6). Last year's number was 63% (data from 2004 and 2005 is not suitable for comparison).

Care Consistent with Advance Directive

- Of the residents with an advance care directive, 99% receive care that is consistent with the directive. Compared to previous years:

2004	2005	2006	2007
98%	99%	96%	99%

This reassuring trend indicates that advance care directives perform the function for which they were intended. They allow the individual to receive the type of care they choose.

Some Other Advance Care Directive Options

Of interest to note in this year's survey:

- 57% of residents have chosen an out of hospital do not resuscitate option. Last year the number was 55% and there is no further prior data.

- 16% of the plans address artificial nutrition and hydration. This was a new question in 2007 and will be trended over time.

These specific types of advance care planning documents can eliminate the need for uncertainty in the event of a medical crisis.

The Durable Medical Power of Attorney
The Durable Medical Power of Attorney document identifies who an individual chooses to make medical decisions for them if they are no longer able to do so. This type of document is very helpful for all people, especially the elderly.

- In 2007, 29% of residents in nursing facilities have a Durable Medical Power of Attorney document, which is the same rate as in 2006.

Both years of data indicate that most residents do not have a Durable Medical Power of Attorney.

Palliative Care
Palliative care is a medical approach designed to treat the symptoms of an illness or disease rather than to cure it. It focuses on relief of suffering through treatment of pain and hence improves quality of life (World Health Organization (WHO) Definition of Palliative Care). Palliative care can be used in conjunction with other therapies to prolong life or it can be used in conjunction with hospice-based therapies. Residents in nursing facilities are offered the choice of a palliative care program upon admission into the facility so that they have a plan in the event of extreme suffering or an end of life situation.

- 7% of residents in nursing facilities have a palliative care choice documented. Compared to previous years:

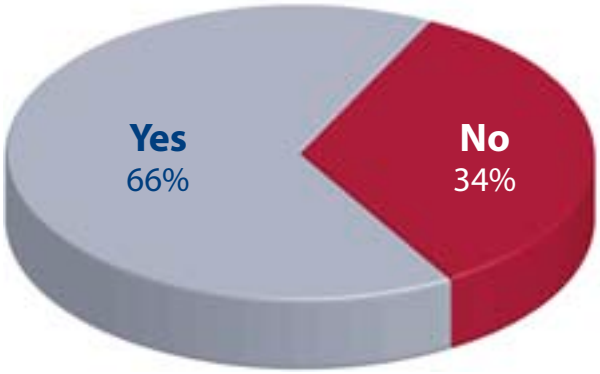
2004	2005	2006	2007
7%	6%	7%	7%

This trend indicates consistent levels of the proportion of people who have a documented palliative care plan in the event one is needed.

Bottom Line
While it is reassuring to know that care is consistent with advance directives, further efforts are needed to obtain more specificity in the advance care documents which exist, such as specifying out of hospital resuscitation and artificial feeding options, and to secure a Durable Medical Power of Attorney for every resident in a nursing facility.

Figure 3.6 – Advanced Care Planning

Do residents have any type of Advance Care Directive?



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

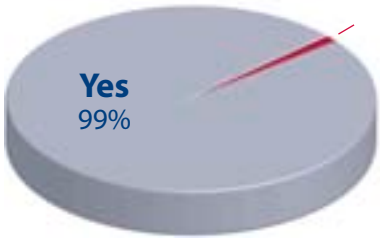
Types of Advance Care documents:

- Out of hospital do not resuscitate
- Directive to physicians
- Do not resuscitate
- 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."

Is care consistent with resident's Advance Care Directive?



[Q8.5]

Residents with a do not resuscitate order

57%

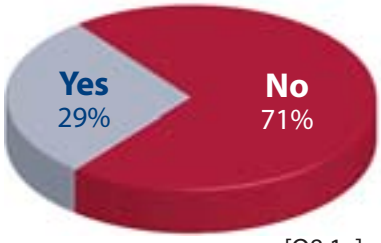
Out of hospital, do not resuscitate.

[Q8.1d]

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

Does the resident have Durable Medical Power of Attorney?

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



[Q8.1a]

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Quality Assurance & Improvement

3.7 Nutrition, Unintended Weight Loss, and Hydration

Nutritional assessments are intended to ensure 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). In addition, malnutrition and unintended weight loss are associated with increased hospitalizations, risk of pressure ulcers, infection rates, heart failure, and mortality. The most common causes of unintended weight loss in residents of nursing facilities are cancer, gastrointestinal disorders, endocrine diseases, infections, medications, cardiovascular disease, and nervous system disorders, including depression (Hall, 2003).

This is the first year the NFQR included questions on nutrition, hydration, and unintended weight loss. The questions were designed to determine if nutritional assessments are conducted, and if a person is at risk for unintended weight loss or dehydration. Survey questions also explored whether goals are identified for the prevention of unintended weight loss or dehydration in at-risk patients.

- When surveyed, residents in nursing facilities have their current nutritional status assessed either upon admission into the nursing facility or annually 93% of the time (figure 3.7).

Risk factors for weight loss include confusion, dementia, poor teeth or missing teeth, difficulty swallowing, and inability to feed oneself.

- 65% of residents were identified at-risk for weight loss.
    - Of these, 74% have care plan goals which address weight.

Dehydration risk factors include difficulty holding a glass or swallowing, swallowing only thickened liquids, age greater than 85, diuretic usage, confusion, and dementia.

- 53% of residents were identified at-risk for dehydration.
    - Of these, 70% have measurable hydration goals.

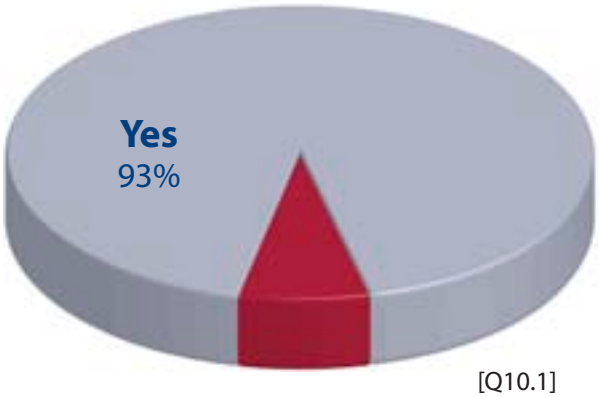
As this was the first year of survey questions on this topic, there is no comparative data.

The amount of food eaten is also related to the type and variety of food offered, how the food is prepared and presented, and the social setting of meals. Section 3.12, Quality of Life, lists the residents' survey responses related to the dining experience in nursing facilities.

Bottom Line
This year was the first time residents were assessed if they had risk factors for unintended weight loss and dehydration. Of those with risk factors, the majority have specific care plans to address weight loss and/or hydration. Future surveys will trend this data.

Figure 3.7 – Nutrition, Unintended Weight Loss & Hydration

Do residents of nursing facilities have an initial or annual nutritional assessment?

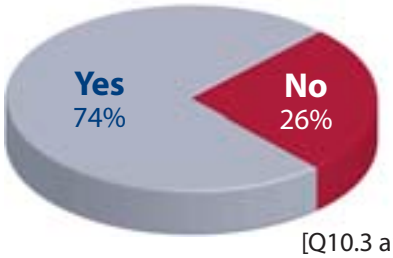


[Q10.1]

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

Of the 65% residents at risk for weight loss

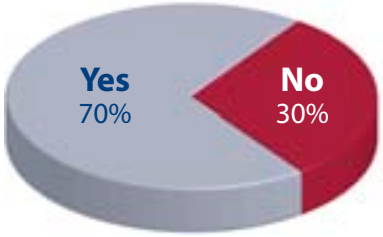
How many have care plan goals for weight?



[Q10.3 and 10.4]

Of the 53% residents at risk for dehydration

How many have measurable hydration goals?



[Q10.5 and 10.6]

For all residents

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

[Q10.2]

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Quality Assurance & Improvement

3.8 Artificial Nutrition and Hydration

Artificial feeding and hydration is commonly called tube feeding. The most common route to accomplish tube feeding is the percutaneous endoscopic gastrostomy (PEG) tube, which is used to feed individuals who cannot swallow. The PEG tube is surgically inserted from an opening through the abdominal skin and extends directly into the stomach. The issues surrounding the use of feeding tubes, especially in persons who have dementia or at the end of life, are both medical and ethical and have been the subject of considerable national debate.

Proportion with a Feeding Tube

- The review indicates 7.5% of residents in a nursing facility have a feeding tube in place (figure 3.8). Compared to previous years:

2005	2006	2007
8.2%	7.4%	7.5%

Documented Consent for Placement

- Of those with feeding tubes, 37% have evidence in the medical chart that documents consent to placement of the feeding tube, which represents a statistically significant increase over years past:

2005	2006	2007
29%	10%	37%

While medical practice requires informed consent prior to any medical procedure, if a person lacks the mental capacity to make decisions then physicians rely on advance directives or family members for treatment consent. In situations where there are no advance directives which specify the person's wishes, or family members are not available, the physician becomes the decision maker. In these emergent situations, physicians usually act to preserve life as long as the expected benefit of treatment is anticipated to outweigh the burden of treatment on the patient. Hence, a feeding tube may sometimes be placed in an individual without expressed consent for treatment (Milkes). In some cases, a physician may call for the opinion of an ethics committee to assist in decision making.

Use of Feeding Tubes More than 30 Days
Residents with feeding tubes in place for 30 days or longer need periodic assessment to ensure their nutritional goals are being met.

- Of those residents with a feeding tube in place for more than 30 days, 55% have been reassessed in the past 30 days. Comparatively:

2005	2006	2007
39%	18%	55%

This trend indicates residents with a feeding tube are being more routinely reassessed.

Feeding Tubes in Place and Not Used
A new question added to this year's survey inquired if a feeding tube has been in place but not used in over 30 days.

- 6% of the feeding tubes in place had not been used in the last 30 days

The intent of the question is to determine if the resident is now taking food and fluid by mouth and if the tube was left in place to ensure that the resident will maintain their eating status. This question will be asked in future surveys and trended over time.

Feeding Tubes in People with Dementia or at the End of Life
The utility of feeding tubes in people with advanced dementia or at the end of life is controversial, with a range of medical and ethical opinions. Some medical studies and positions recommend investigation as to why the person with dementia is not eating. Others support the opinion that tube feedings do not show increased comfort in people with cancer or dementia. Still others support honoring the individual's expressed wish to feed or to refuse artificial feeding (McCann).

In Texas nursing facilities, the proportion of residents with feeding tubes who also have any of the following conditions was surveyed:

- Late stage dementia;
- End-stage metastatic cancer;
- Organ failure; or
- Score poorly (three or greater) on the 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 Performance Status, ECOG).

The results of the survey indicate that:

- The proportion of people with feeding tubes and receiving artificial nutrition and hydration for which there is no supported medical basis for expecting benefit is 31%. While this is the same proportion as 2006, the trend overall is decreasing:

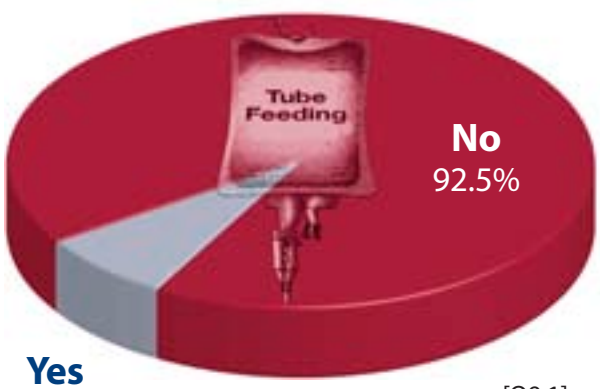
2005	2006	2007
38%	31%	31%

Bottom Line
The issue of whether or not a feeding tube is placed with consent can be mitigated by advance care plan documents which specifically address the issue of nutrition and hydration. Residents with feeding tubes need improved rates of reassessment to ensure nutritional goals are met.

Figure 3.8 – Artificial Nutrition and Hydration

Tube Feeding

Do residents receive tube feeding?

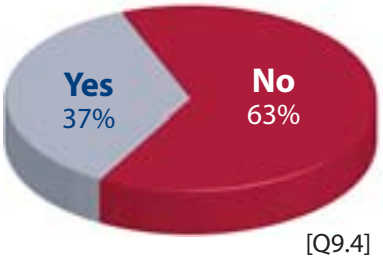


[Q9.1]

- 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 surgically placed feeding tube that opens directly into the stomach from an opening outside the skin. A PEG tube is commonly used to feed those who cannot swallow.

Of residents receiving tube feedings

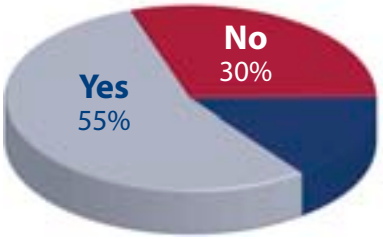
Is there evidence of informed consent?



[Q9.4]

Of residents receiving tube feedings > 30 days

Are their nutritional goals being regularly assessed?

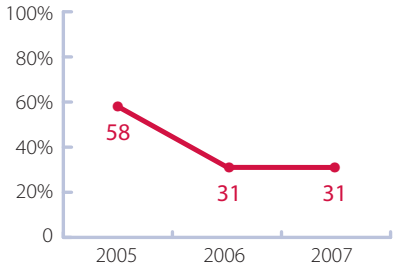


15% Answered "not applicable"

[Q9.5 and 9.6]

Of residents receiving tube feedings

Proportion with no rational medical basis for expecting benefit



[Q9.3]

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Quality Assurance & Improvement

3.9 Infectious Illnesses

Prevention of infection, infection control, and the reduction of antibiotic resistant strains of infections are important in any institutionalized setting and are especially important in a nursing facility. Nursing facilities, as in any common living situation, are environments in which the acquisition and spread of infections can potentially affect many people and is of special concern if a person is medically compromised or frail, for whom the consequences may be dire (Strausbaugh, 2003).

Types and Rates of Infection in Nursing Facilities
Infections among residents of nursing facilities occur frequently and are usually urinary tract infections, skin and soft tissue infections, or pneumonia (Nicolle, 1996). The NACES survey found a slight increase in the number of infections compared to 2006:

	2006	2007
Urinary Tract Infection	3.7%	3.5%
Skin Infection	2.0%	2.2%
Pneumonia	0.7%	0.9%
Diarrhea & Fever	0.0%	0.1%
Other Infection	4.1%	4.9%

- The percentage of residents with infections in 2007, including single or multiple infections in a single individual, is 11%, up from 10% in 2006.

Resistant Infectious Agents
The use of broad spectrum antibiotics has been attributed to antibiotic resistance (Weiner, 1999). Two of the most prevalent bacteria exhibiting antibiotic resistances 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, the reported cases of antibiotic resistance have declined:

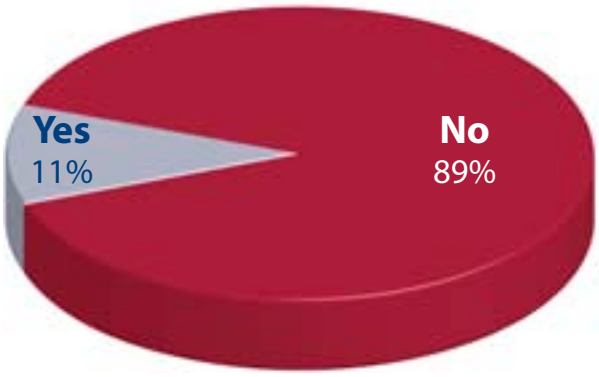
	2006	2007
MRSA Infections	0.4%	0.3%
VRE Infection	0.1%	0.0%

While the specific causes for the decrease in the number of antibiotic resistant cases was not studied as part of the survey, it is most likely multi-factorial. This encouraging trend will be monitored over time.

Bottom Line
While overall infection rates slightly increased, the number of resistant infections is declining.

Figure 3.9 – Infectious Illnesses

Has the resident had any infection in the past seven days?



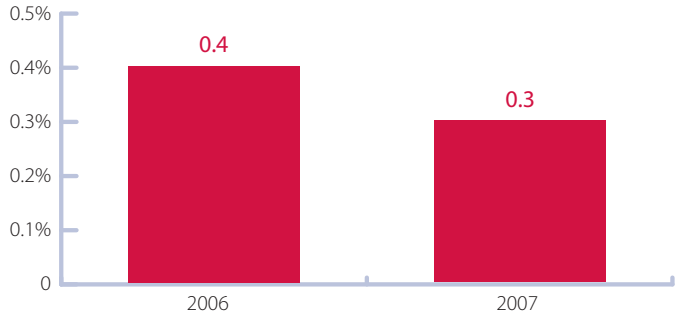
- 4% had a urinary tract infection [Q4.1]
- 2% had a skin infection [Q4.2]
- 0.9% had pneumonia [Q4.3]
- 0.1% had diarrhea and fever [Q4.4]
- 5% had "other" infection [Q4.5]

Antibiotic resistance

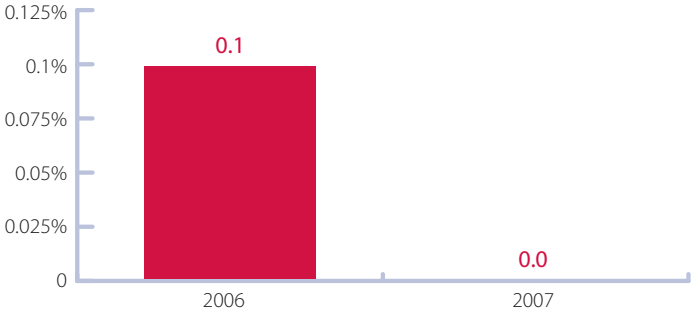
Infectious agents are becoming increasingly resistant to antibiotics; two of the most prevalent are:

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

How many infections were MRSA?



How many infections were VRE?



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Quality Assurance & Improvement

3.10 Medication Practice and Safety

Medication Administration Records

The resident's physician determines and orders the specific prescription and over-the-counter substances needed and delegates administration of the ordered items to the nursing facility staff. The staff annotates every prescription and over-the-counter substance given to a resident, including the dosage, date and time of administration, in the Medication Administration Record (MAR). Hence, the MAR is a complete accounting of all the substances the nursing facility actually administered to the resident. Facilities are required to report the MAR to CMS.

The survey included cataloging the residents' MARs by NACES pharmacists.

3.10.1 Prescribed Medicines

Number of Medications and Over the Counter Substances

- When the medications on this year's MARs list are counted, the data indicates an average of 11.20 prescription medicines and over-the-counter substances are authorized per resident per day. Compared to previous years' MARs, there has been a slight decrease since last year:

2005	2006	2007
11.23	11.34	11.20

Deleting the Over-the-Counter Substances

When the MARs data is adjusted to delete the over-the-counter substances, the remaining figure is the count of prescription medicines.

- Eight prescription medicines are authorized, on average, per resident per day. Compared to previous years' data, the findings indicate a relatively flat trend:

2005	2006	2007
8.07	8.10	8.08

Adjusting for Combination Prescription Medicines

Some of the prescription medications ordered are actually two medicines combined into one (usually pill or tablet). While this has the effect of reducing the overall number of pills or tablets for the resident, as well as the number of medicines the facility staff needs to administer, the resident is actually receiving an increased number of prescription medicines than indicated by the raw count of the number of pills or tablets.

- When all the individual medicines are counted in the combination medicines, the actual number of **prescribed medicines** per resident, per day is (figure 3.10):

2005	2006	2007
8.94	8.97	8.84

3.10.2 Potential for Drug Interactions and the Top 10 List

Potential for Drug Interactions
The number of prescribed medicines is important because the potential for drug interaction and adverse drug reaction increases with the number of medications. Research indicates patients receiving eight or more drugs have a 100% chance of a drug interaction (Sloan, 1983).

- The proportion of residents receiving nine or more prescription medicines in 2007 is 8.20% and compared to previous years indicates a slight decrease:

2005	2006	2007
8.54%	8.66%	8.20%

The Top 10 List
A list of medications known to result in adverse outcomes when combined is the "Top 10" list (Brown).

- The proportion of residents whose medication regimen includes at least one medicine from the Top 10 list is 11.1% and compared to previous years indicates a slight decline (figure 13.10):

2005	2006	2007
11.5%	11.8%	11.1%

The most common Top 10 combination in use is the class of blood pressure medications, angiotensin-converting-enzyme-inhibitors, combined with a potassium supplement.

- This year 8.7 % of residents were noted to be on that combination, which compares to previous years:

2005	2006	2007
8.7%	9.5%	8.7%

The adverse effects of this combination can be mitigated with use of a diuretic. When the 2007 data was reviewed and adjusted for that, 1.4% of all residents were noted to be on the hazardous combination, the same as reported in 2006, and slightly increased from 1.0% reported in 2005.

3.10.3 Beers List

The Beers list, named for its originator, Dr. Beers, 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; 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 are reviewed, the proportion of residents receiving at least one medication from the Beers list is 17%, and comparatively (figure 3.10):

2005	2006	2007
16%	15%	17%

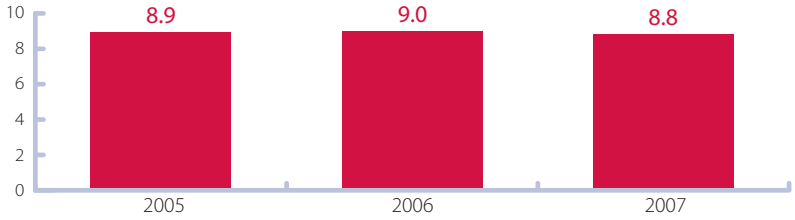
The most common Beers list medication is digoxin, used commonly for heart failure. Digoxin dosing requires individualized regimens to ensure optimal drug levels. Inappropriate digoxin levels can lead to increased emergency room visits.

Bottom Line
Residents are being prescribed slightly less prescription medicines than in years past and the potential for drug-to-drug interactions has slightly decreased. The proportion of residents on medications that are potentially inappropriate for older persons has slightly increased. The findings do not indicate statistically significant differences from prior years.

Figure 3.10 – Medication Practice and Safety

Prescribed medicines

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



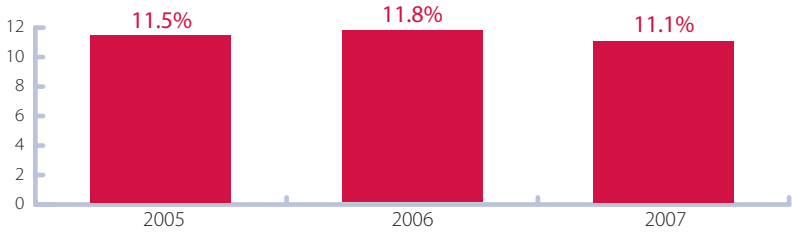
For residents on nine or more active ingredient medications:

8.2%

Have the potential for a drug interaction.

Top 10 drug interactions**

How many residents' medication regimen includes a Top 10 Interaction?



**Medications associated with adverse outcomes

Most common Top 10 Drug Interaction is:

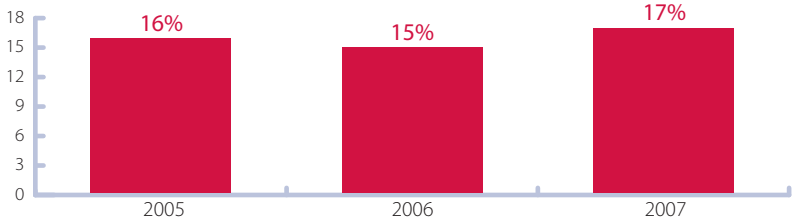
ACE-I plus K+ = **8.7%**

(Angiotensin Converting Enzyme Inhibitor plus potassium)

If mitigated by a diuretic = **1.4%**

Beers List*

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



*Medications generally avoided in the elderly

Most common medication on the Beers List is:

Digoxin

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Quality Assurance & Improvement

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3.11 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 their use in the elderly, especially in those with cognitive impairment, as these medicines can affect alertness which can lead to falls, fractures, hemorrhage, or delirium (Gurwitz, 2000).

3.11.1 Antipsychotic Medications

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

Proportion on Antipsychotic Medication(s)

- In 2007, 32% of all residents are prescribed at least one antipsychotic medication (figure 3.11):

2005	2006	2007
34%	33%	32%

This trend indicates a relatively static trend in the use of antipsychotic medications.

Documented Medical Indication for Antipsychotic Medication

The appropriateness of the use of antipsychotics is based on a clinical indication (diagnosis) 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 danger to self or others.

The NACES pharmacists checked the appropriateness for the use of an antipsychotic medication.

- 82% of residents on an antipsychotic medication have an appropriate clinical indication. Comparatively:

2005	2006	2007
58%	59%	82%

This trend indicates a statistically significant improvement in the appropriate use of antipsychotic medications.

Typical and Atypical Antipsychotic Medications

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

- Of the people on antipsychotic medications, the breakout of typical to atypical antipsychotic use is (Note: Some people are on both a typical and an atypical antipsychotic, hence the numbers add up to over 100%):

	2005	2006	2007
Typical	14%	14%	13%
Atypical	93%	94%	92%

The 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 FDA). Behavioral symptoms, such as hitting, yelling, or screaming, can be seen in people with dementia or who are experiencing pain. Atypical antipsychotic medications used to control behavioral symptoms in this off-label fashion have been associated with an increased risk of sudden death (U.S. FDA Public Health Advisory, April 2005).

- The proportion of residents on an atypical antipsychotic medication without a clinical indication is 29%, and comparatively:

2005	2006	2007
41.3%	40.8%	28.9%

This trend indicates a statistically significant improvement in the prescribing practices of atypical antipsychotic medications, thereby reducing the risk of sudden death.

3.11.2 Anti-Anxiety Medications

Proportion on Anti-Anxiety Medications

- The proportion of all residents on anti-anxiety drugs, also called anxiolytic medications, is 20% (figure 3.11). Compared to previous years, this represents a statistically significant reduction:

2004	2005	2006	2007
26%	29%	30%	20%

Medical Diagnosis of Anxiety

While anxiolytic medications are appropriate for the management of medically diagnosed anxiety disorders, previous NFQR surveys have noted these medications administered to persons without a diagnosed anxiety disorder in their medical chart.

- In 2007, 7% of all residents in nursing facilities have a doctor-diagnosed anxiety disorder. Compared to previous years:

2004	2005	2006	2007
17%	12%	7%	7%

Reassessment of Anxiety Symptoms

- Of the residents diagnosed with anxiety (7%), 19% of them are assessed at least every two weeks for the stated, measurable goals of anti-anxiety therapy. Compared to previous years:

2004	2005	2006	2007
45%	23%	6%	19%

Over the last several years the proportions of residents on anxiolytic medications and diagnosed with an anxiety disorder have declined. Since last year, regular anxiety symptom assessment towards measurable goals has increased. These trends suggest periodic, regular assessment of anxiety symptoms may account for the overall reduction in the use of anxiolytic medications.

Comparative MDS Data

The resident's mood and behavior observed by the NACES reviewer was compared to that which is recorded in the MDS and indicates a 94% favorable comparison rate. There is no previous comparative data.

3.11.3 Sedative/Hypnotic (Sleep) Medications

Daytime sleepiness and nighttime sleep disturbances are common problems in residents of nursing facilities (Martin, 2006).

Proportion of Residents who Report Sleep Problems

- 5% of all residents complained of sleep problems in the past 14 days and when trended indicate a decrease in reported sleep problems:

2004	2005	2006	2007
8%	9%	6%	5%

Proportion on Sleep Medications

- 13% of all residents in nursing facilities are prescribed sleep medications, which is the same proportion as last year (figure 3.11):

2004	2005	2006	2007
11%	16%	13%	13%

Effectiveness of Sleep Medications

- Of the residents on a sleep medication, 21% report continuing sleep problems. Compared to previous years:

2004	2005	2006	2007
41%	31%	25%	21%

The above trends, while improving, indicate that sleep problems continue to be a concern for residents in nursing facilities. Despite medication, residents report continued sleep problems, which suggests medication ineffectiveness or others factors may be contributing to continued sleep disturbances.

Bottom Line

While rates of antipsychotic medication use have stayed relatively constant, improved prescribing practices have resulted in more appropriate usage (when clinically indicated) and of these medicines. These improved prescribing practices reduce the risk of sudden death associated with the off-label use of atypical antipsychotic medications. Improved assessment of anxiety appears to have resulted in a decrease in the use of anxiolytic medications. Reported sleep problems have improved however, sleep issues still affect one-fifth of the residents, suggesting sleep issues may be related to other medical or environmental issues.

Figure 3.11 – Psychoactive Medications

Antipsychotics	Accepted indication?	Off-label use?
Proportion of residents receiving antipsychotic drugs: **32%**	Of those receiving an anti-psychotic drug, how many have an accepted indication? **82%**	Of those receiving an atypical antipsychotic drug, how many do not have a clear indication? **29%**
Anxiolytics	**Medical diagnosis?**	**Regular reassessment?**
Proportion of residents receiving anxiolytic drugs: **20%**	Of all residents, how many have a medical diagnosis of anxiety? **7%** [Q11.1]	Of those receiving anxiolytic drugs, how many are reassessed at least every two weeks? **19%** [Q11.5 and 11.1]
Sleep medications	**Report sleep problems?**	**Medication effective?**
Proportion of residents receiving sleep drugs: **13%** [Q12.3]	Of all residents, how many report sleep problems? **5%** [Q12.1]	Of residents on sleep drugs, how many report continued sleep problems? **21%** [Q12.3 and 12.1]

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Quality Assurance & Improvement

3.12 Quality of Life

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

All residents in the survey were asked the questions in this portion of the assessment. If after a reasonable attempt the resident was unable to respond, then a resident's family member or guardian was solicited to answer the questions. This year:

- 69% of the residents directly responded to the questions;
- 15% of the residents' family member or guardian answered; and
- 16% of the residents and their representative did not respond.

Of interest, when the responses were analyzed between the residents' responses versus the family member or guardian responses, the overall survey results matched.

- When asked how satisfied they were with their overall experience in the nursing facility, the responses indicate **75% are "satisfied" to "very satisfied."** The complete breakout of responses (figure 3.12a) and comparison to previous' years results are:

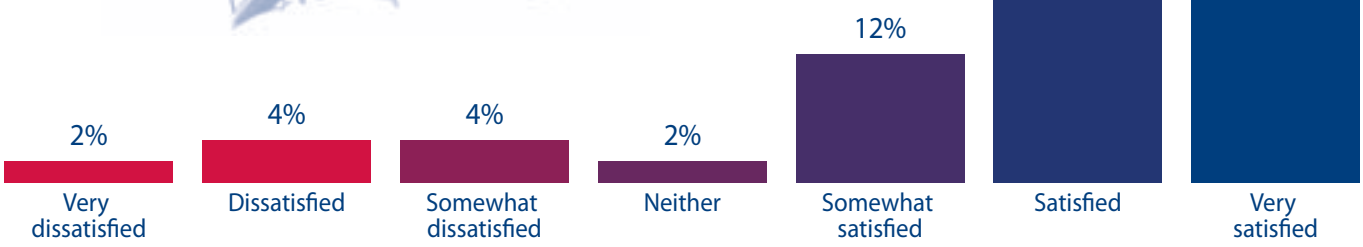
Overall satisfaction with Quality of Life	2004	2005	2006	2007
Very Satisfied	30%	28%	19%	**25%**
Satisfied	43%	48%	52%	**50%**
Somewhat Satisfied	18%	15%	13%	12%
Neither	1%	2%	7%	2%
Somewhat Dissatisfied	5%	4%	4%	4%
Dissatisfied	2%	2%	3%	4%
Very Dissatisfied	1%	1%	2%	2%
No answer	1%	1%	1%	1%

This trend indicates a fairly static range of residents in the "satisfied" to "very satisfied" range (70% - 76%) over the last several years (2004 through 2007), with an improvement noted this year in the proportion of residents indicating they are "very satisfied".

Figure 3.12a – Overall Quality of Life

Overall, how satisfied are you with your or your family member's experience in this nursing facility?

1% responded "not applicable" [Q13.12]



[Q13.17]

- 69% of residents completed the Quality of Life survey;
- 15% of residents' family members or guardians completed this section (if the resident was not able to after a reasonable attempt was made);
- 16% of the residents or their representatives did not respond.

[Q13.1]

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Further resident responses were solicited involving quality of life in several areas including food and mealtimes, activities, socialization and privacy, and about their safety and possessions. This is the second year the following, more in-depth questions, have been asked directly of the residents or their representatives [Note: Proportional responses indicate a "yes" answer].

Food and Mealtimes (figure 3.12.b)	2006	2007
Do you like the food here?	71%	75%
Do you enjoy mealtimes here?	74%	81%
Can you get your favorite foods here?	50%	52%

- All indicators in food and mealtime enjoyment increased; however, residents want access to their favorite foods.

Activities (figure 3.12c)	2006	2007
Do you participate in religious activities here?	58%	63%
Do you enjoy the organized activities here?	58%	63%
Do the religious observances here have personal meaning for you?	59%	60%
Outside of religious activities, do you have enjoyable things to do at the nursing home during the weekends?	33%	33%

The residents' ratings of activity options are slightly improved as compared to last year's ratings. Residents clearly desire more activities, especially on the weekends and generally want improvement of the activities currently offered.

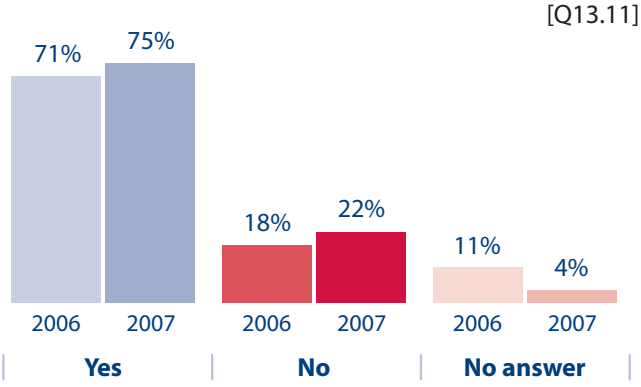
Socialization and Privacy (figure 3.12d)	2006	2007
Can you find a place to be alone when you wish?	70%	66%
When you have a visitor, can you find a place to visit in private?	75%	74%
Can you make a private phone call?	71%	72%
Can you be together in private with another resident (other than their roommate)?	52%	52%

- Privacy indicators stayed essentially the same, except the noted decline in the residents' ability to be alone when they wish. Privacy overall continues to be a resident concern.

Figure 3.12b – Quality of Life – Dining Experience

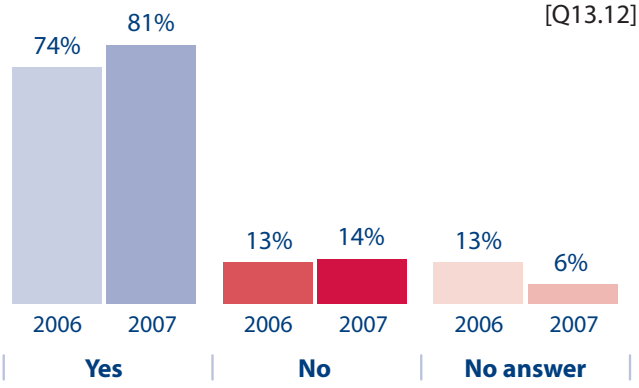
Do you like the food here?

[Q13.11]



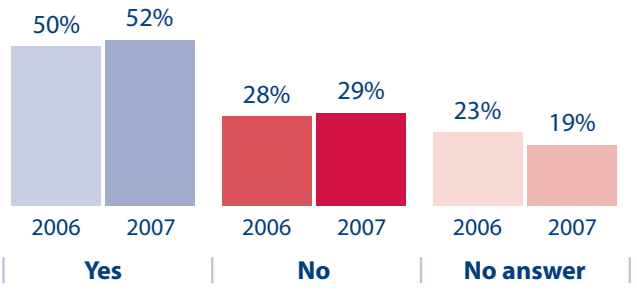
Do you enjoy mealtimes here?

[Q13.12]



Can you get your favorite foods here?

[Q13.13]



- 69% of residents completed the Quality of Life survey;
- 15% of residents' family members or guardians completed this section (if the resident was not able to after a reasonable attempt was made);
- 16% of the residents or their representatives did not respond.

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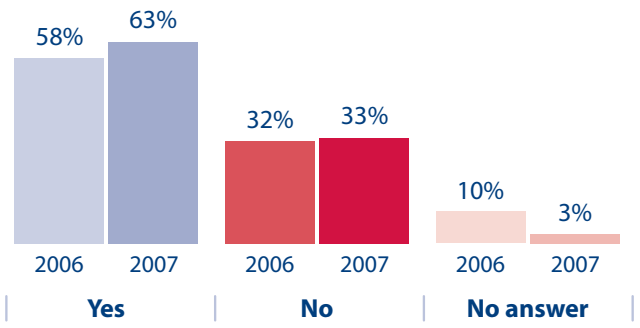
Figure 3.12c – Quality of Life – Activities

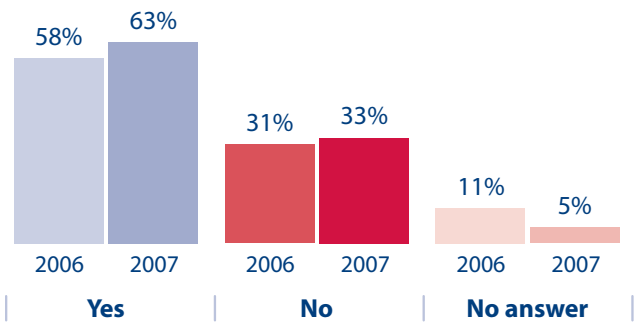
Do you participate in religious activities here?

[Q13.7]



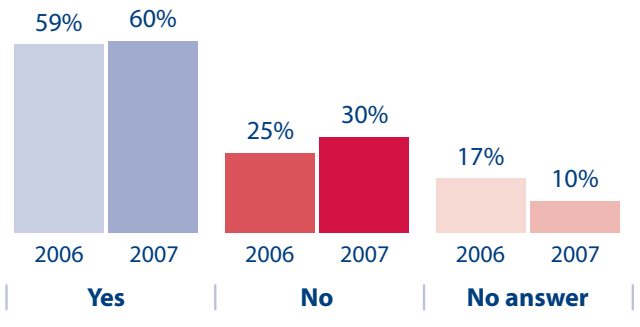
Do you enjoy the organized activities here?

[Q13.9]



Do the religious observances here have meaning for you?

[Q13.8]



Outside of religious activities, do you have enjoyable things to do here on the weekends?

[Q13.10]

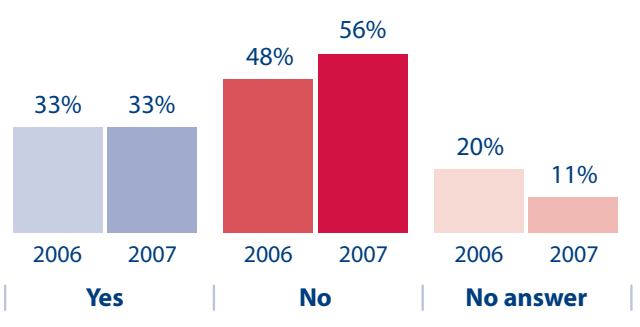


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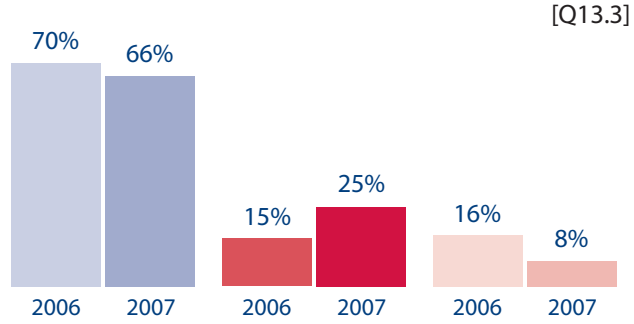
Figure 3.12d – Quality of Life – Socialization & Privacy

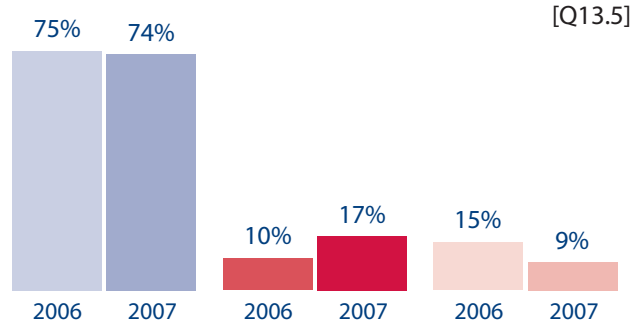
Can you find a place to be alone when you wish?

[Q13.3]



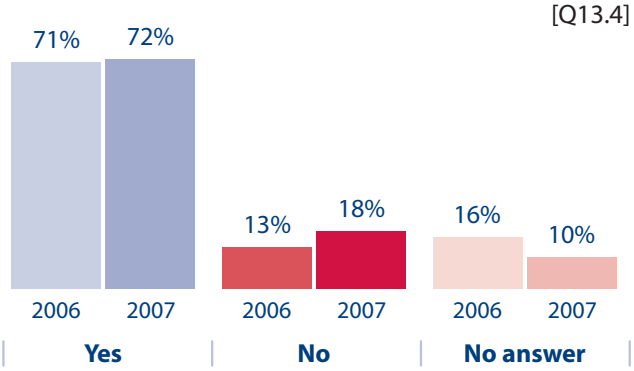
When you have a visitor, can you find a place to visit in private?

[Q13.5]



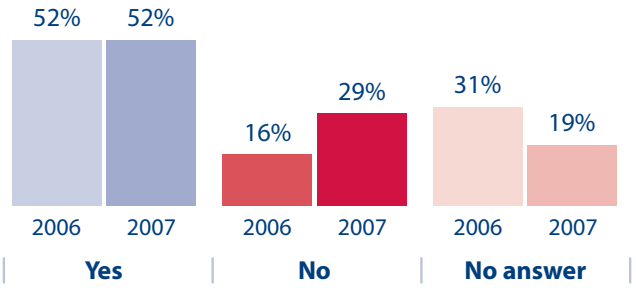
Can you make a private phone call?

[Q13.4]



Can you be together with another resident (other than your roommate)?

[Q13.6]



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Safety and Possessions (figure 3.12.e)	2006	2007
Do you feel that your possessions are safe at this nursing home?	69%	75%
Do you get your clothes back from the laundry and undamaged? [Note: The question was asked "Do your clothes get lost or damaged in the laundry?" but re-worded for consistency so that an affirmative response would be consistent with the yes/no format of the other questions in quality of life.]	48%	57%
Do you feel safe and secure?	85%	91%

Residents indicated increased feelings of safety and security as compared to last year.

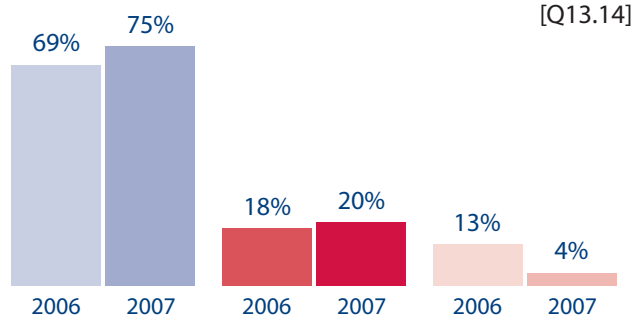
Bottom Line

While the residents' rating on overall quality of life improved slightly, this year's findings indicates many residents clearly want to be able to get their favorite foods, want more privacy options, and want more activity options, especially on the weekends.

Figure 3.12e – Quality of Life – Safety & Possessions

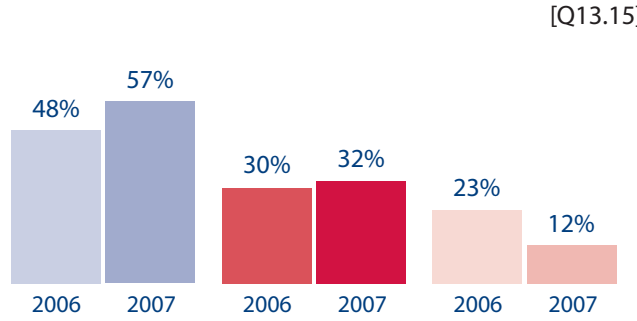
Do you feel your possessions are safe here?

[Q13.14]



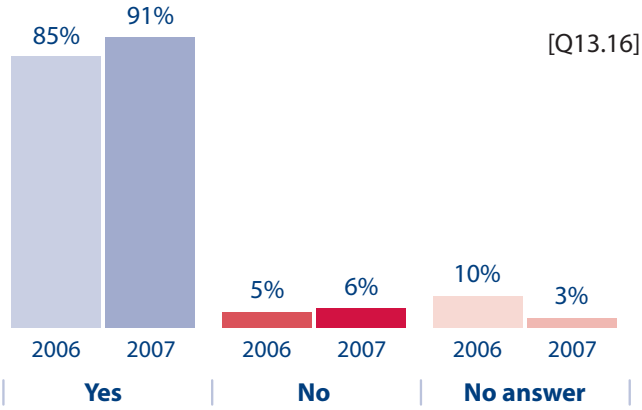
Do you get clothes back from the laundry and are they undamaged?

[Q13.15]



Do you feel safe and secure?

[Q13.16]



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Quality Assurance & Improvement

4.0 Recommendations

The findings of the Nursing Facility Quality Review (NFQR) 2007 identify quality of care and quality of life areas which have either improved, stayed relatively the same, or which need attention. The Texas Department of Aging and Disability Services (DADS) uses these findings to affect the overall Lon Term Support Services (LTSS) healthcare delivery system in several ways:

- Present these findings to key personnel in the LTSS industry, conduct strategic reviews, and promote quality improvement;
- Review internal DADS programs and make program changes in areas where DADS has a direct influence; and
- Involve consumer advocates in the change process.

4.1 Existing DADS Programs

Quality Monitoring Program

Some of the quality of care items noted in this year's report will involve modification of the existing DADS Quality Monitoring Program (QMP) content or development of new subject matter for the QMP. One of those improvements will be to update the technical content in the use of antipsychotic medications module of the program using the recently received results of the systematic literature review (SLR). SLRs have been performed by researchers at Texas A&M University and provide the latest information on evidence-based best practices. Two other SLRs provide information in two new focus areas, pressure ulcers and dementia care, and are being added to the QM program for deployment statewide to nursing facilities in 2008.

Other specific changes in the topic areas involving nursing, nutrition, and pharmacological disciplines are being considered with specific change plans scheduled for implementation in 2008. These topic areas include improvements in:

- Promoting urinary continence;
- Prevention strategies for fall risk management, including osteoporosis prevention strategies;
- Improving vaccination rates;
- Improving pain control;
- Addressing measurable nutritional goals of persons receiving artificial nutrition and hydration;
- Reducing polypharmacy;
- Preventing dehydration and unintended weight loss; and
- Promoting use of advance directives to include artificial nutrition and hydration clauses to avert potential placements of feeding tubes without explicit consent.

As many of these areas are interdependent (e.g., fall prevention has nursing, nutritional, and pharmacological components), improvement recommendations will be the result of collaboration among the affected disciplines.

Long-Term Care Ombudsman
The DADS statewide Long-Term Care (LTC) 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. Statewide, LTC Ombudsmen are trained on "culture-change" to promote individual freedom and choice for residents. As a result of this year's NFQR, the Ombudsmen will be part of the strategic team to explore how DADS can effect change to promote resident privacy options, increase dining options and accessibility to favorite foods, and expand weekend activity options. In the 2008 NFQR assessment, residents will be asked about the availability and effectiveness of the Ombudsmen.

Advance Care Planning Work Group
The DADS Pilot Project on Advance Care Planning SB 27, 80th Legislature, Regular Session, 2007) is reviewing the education process provided to residents of nursing facilities and intermediate care facilities/mental retardation, and to their families, on advance care planning documents. Final analysis from the Pilot Project is due to the Governor and the Legislature by October 2010.

Texas Falls Prevention Coalition
DADS Quality Assurance and Improvement Unit is sponsoring 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. The Coalition began in June 2007, and is charged to improve fall prevention and change 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 environments to reduce fall risk factors, and learn 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 ultimately reach local communities and seniors.

Aging Texas Well
DADS Aging Texas Well (ATW) Program, which includes Texercise, is an initiative that promotes activity in all Texans, helps ensure Texans prepare individually for aging in all aspects of life, and the state and local infrastructure of laws, policies and services support healthy aging throughout the lifespan. The ATW Program identifies and discusses aging policy issues, guides state government readiness, and promotes increased community preparedness for aging Texans. It is accomplished through efforts within DADS, in other agencies, and in businesses and communities across the state. Part of improving quality of life for older Texans involves the practice of preventative and evidence-based health strategies, such as those utilized in the demonstration project Texas Healthy Lifestyles carried out in three communities across Texas. This and other ATW activities result in improved self-reported health status and symptom management, improved health behaviors, and reduced utilization of unnecessary heath care resources.

4.2 Collaborative Efforts

DADS collaborates with providers, medical directors, directors of nursing, and other staff- members of nursing facilities through several ongoing programs. One ongoing effort is through the DADS Quality Monitoring program in which quality consultants work directly with staff of nursing facilities to provide information on evidence based best practices in over twelve focus areas. Other forums for exchange of information involve DADS collaboration with several coalitions. DADS participates in strategic planning with:

- Leadership staff of nursing facilities;
- Representatives of non-profit organizations focused on the aging, such as the:
    - Texas Healthcare Association;
    - Texas Association of Area Agencies on Aging;
    - Texas Association of Homes and Services for the Aging; and
- TMF (not an acronym) Health Quality Institute.

In addition, DADS plans to hold a Geriatrics Symposium in 2008 to present the findings of the 2007 NFQR assessment and topics relevant to the quality of care and quality of life in nursing facilities. As in years past, the chosen topics feature subject-matter experts. Audience members include administrators of nursing facilities, directors of nursing, pharmacists, nutritionists, therapists, and social workers directly involved in the care of residents in nursing facilities.

Future NFQR assessments

After change plans have been formulated and implemented, future NFQR assessments will be designed to ensure the instituted changes are producing improved outcomes. Any areas in which maximum achievements have been made, such as in the number of people with indwelling bladder catheters, will be removed for the assessment. New topic areas, such as pressure ulcers, the use of inappropriate restraints, the identification of specific areas of resident concern, and to elicit the residents' assessment of their quality of care are planned for the NFQR 2008 assessment.

5.0 Conclusion

The Long Term Support System (LTSS) which affects an individual's overall experience in the nursing facility includes federal and state regulations, the individual's personal physician, the nursing facility and staff, the individual's personal support group, as well as the individual's personal health.

The Nursing Facility Quality Review (NFQR) for 2007 assessed a sample of residents in nursing facilities across Texas in the areas of quality of care and quality of life. The findings indicate areas of improvement, areas of no change, and areas which have declined.

These findings are used by DADS to drive proactive tactical and strategic change, both internally and externally. Internal DADS programs, such as improving quality, regulating providers, and promoting consumer advocacy, participate in plans to improve outcomes. Externally, DADS collaborates with all stakeholders to improve the overall quality of the service delivery system.

Future NFQR assessments are designed to measure progress on the implemented changes and explore new topic areas. In so doing, the effectiveness of implemented changes over time is analyzed to ensure positive outcomes are achieved. As areas achieve maximum improvements, new topics are selected for assessment.

The NFQR findings, the resultant change plans, the implementation of the changes and measuring for their desired effects are processes used in DADS to continuously improve and prevent adverse outcomes. These efforts serve the residents of nursing facilities in Texas and support the overarching DADS vision to promote well-being, dignity, and personal choice.

6.0 References

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Appendix A

This appendix contains a complete listing of the questions asked during the 2007 Nursing Facility Quality Review and the survey responses.

The survey questions are based largely on the research of Rosalie Kane, a leading researcher in Gerontology, and various studies she has done on quality of life and quality of care in nursing facilities nationwide.

Of the 118,882 residents in Medicaid-certified nursing facilities in Texas, 2,031 people were randomly selected and surveyed. The responses to the survey questions are included in this Appendix.

Department of Aging and Disability Services

Nursing Facility Quality Review
Resident Assessment

Instructions: CHOOSE ONLY ONE ANSWER FOR EACH QUESTION that offers a choice of responses. Questions marked with an asterisk (*) MUST be answered. Please print clearly.

Part 1. Identifying Information

1.1* Date of Assessment **___ ___/___ ___/2007**

1.2* Facility's Texas Vendor Number **_____**

1.3* Quality Review Nurse's Identifier Number **___ ___ ___ ___**

1.4* Resident's DADSID **_____**

1.5* Resident's Name **_____ ____ _____**
First Name MI Last Name

1.6* Primary Physician's Name_____ ____ _____
First Name MI Last Name

1.7* Primary Physician's Texas Medical License Number _____

1.8* Does the resident have a palliative plan of care?

O [1] Yes 141 (6.9%) O [2] No 1890 (93.1%)

1.9* How long has the resident resided in this facility?

O [1] 0-3 months 47 (2.3%) O [2] 3-6 months 188 (9.3%) O [3] 6-9 months 176 (8.7%)
O [4] 9-12 months 156 (7.7%) O [5] 1-2 years 475 (23.4%) O [6] more than 2 years 989(48.7%)

NOTE:
For all questions in Parts 2 through 13, with a few exceptions that are noted explicitly in the guidance, each question is meant to be answered independently of all other questions.

Part 2. Assessment of Urinary Continence

Questions 2.1 through 2.8 MUST BE ANSWERED. Questions 2.9 through 2.12 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?

O [1] Yes 878 (43.2%) O [2] No 1153 (56.8%)

2.2* Is the resident <u>unresponsive</u> (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.)

O [1] Yes 43 (2.1%) O [2] No 1988 (97.9%)

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

O [1] Yes 587 (28.9%) O [2] No 1444 (71.1%)

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

O [1] Yes 47 (2.3%) O [2] No 1984 (97.7%)

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

O [1] Yes 123 (6.1%) O [2] No 1908 (93.9%)

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)

O [1] Yes-PV 39 (1.9%) O [2] Yes-SV 170 (8.4%)
O [3] Yes-BR 11 (.5%) O [4] No 1811 (89.2%)

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

O [1] Yes 87 (4.3%) O [2] No 19 (.9%)
O [3] q2h SV 118 (5.8%) O [4] There is no plan 1807 (89%)

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

O [1] Yes 520 (25.6%) O [2] No 1511 (74.4%)

---------- If item 2.8 was answered YES, then skip to Part 2.13 ----------
1511 people responded to this portion of the survey

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

O [1] Yes 1339 (88.9%) O [2] No 168 (11.1)

2.10 Have <u>any</u> of these episodes occurred during normal waking hours?

O [1] Yes 1318 (87.5%) O [2] No 189 (12.5%)

2.11 Are there active, Stage III or IV pressure sores involving the sacrum, trochanters or buttocks? (Those pressure sores that due to LOCATION would prevent toileting, bedpan use, and bedside commode use.)

O [1] Yes 29 (1.9%) O [2] No 1478 (98.1%)

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

O [1] Yes 103 (6.8%) O [2] No 1404 (93.2%)

2.13* Does MDS section H 1b. accurately reflect the resident's urinary continence status?

O [1] Yes 1341 (88.7%) O [2] No 170 (11.3%)

Part 3. Use of Indwelling Bladder Catheter

Question 3.1 MUST BE ANSWERED. Questions 3.2 through 3.9 MUST BE ANSWERED when the answer to 3.1 is YES.

3.1* Does the resident have an indwelling bladder catheter?

O [1] Yes 85 (4.2%) O [2] No 1946 (95.8%)

--------- If item 3.1 was answered NO, then skip to Part 4 ---------
85 people responded to this portion of the survey

3.2 Has the resident had a catheter longer than 6 weeks?

O [1] Yes 71 (83.5%) O [2] No 14 (16.5%)

3.3 Does the resident's medical therapy prescribed by a physician require an indwelling catheter for an accurate intake and output?

O [1] Yes 6 (7.1%) O [2] No 79 (92.9%)

3.4 Does the resident have an indwelling catheter for the purpose of completing a specific diagnostic evaluation?

O [1] Yes 1 (1.2%) O [2] No 84 (98.8%)

3.5 Does the resident have an indwelling catheter that is being used to administer a prescribed medication? (Do not count routine GU irrigant solutions.)

O [1] Yes 0 (0%) O [2] No 85 (100%)

3.6 Was the resident admitted or transferred into the facility within the last 6 weeks?

O [1] Yes 14 (16.5%) O [2] No 71 (83.5%)

3.7 Does this resident have evidence of obstructive uropathy, bladder outlet obstruction, hydronephrosis, detrusor areflexia, detrusor hypo- or hyperreflexia, detrusor-sphincter dyssynergia, vesicoureteral reflux, or infravesicle obstruction due to stricture or prostate pathology? (Answer YES only if there is documentation that urological, urodynamic, or imaging evaluation has shown one or more of the diagnoses in 3.7.)

O [1] Yes 9 (10.6%) O [2] No 76 (89.4%)

3.8 Does the medical record report two or more post-voiding residual (PVR) urine volumes greater than 200cc?

O [1] Yes 3 (3.5%) O [2] No 82 (96.5%)

3.9 Does the resident have active, Stage III or IV pressure sores that would be vulnerable to urinary moisture? (Regardless of location if urine would affect the sores)

O [1] Yes 16 (18.8%) O [2] No 69 (81.2%)

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?

O [1] Yes-MRSA 0 (0%) O [2] Yes-VRE 0 (0%)
O [3] Yes-other 72 (3.5%) O [4] No 1959 (96.5%)

4.2* Has the resident had a skin or wound infection at any time in the last 7 days?

O [1] Yes-MRSA 6 (.3%) O [2] Yes-VRE 0 (0%)
O [3] Yes-other 40 (2.0%) O [4] No 1985 (97.7%)

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

O [1] Yes-MRSA 1 (.0%) O [2] Yes-VRE 0 (0%)
O [3] Yes-other 19 (.9%) O [4] No 2011 (99.0%)

4.4* Has the resident had diarrhea <u>AND</u> fever at any time in the last 7 days?

O [1] Yes-C. dif 0 (0%) O [2] Yes-other 2 (.1%) O [3] No 2029 (99.9%)

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

O [1] Yes-MRSA 1 (0%) O [2] Yes-VRE 0 (0%)
O [3] Yes-other 99 (4.9%) O [4] No 1931 (95.1%)

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.)

O [1] no pain 1319 (64.9%) O [2] mild 150 (7.4%)
O [3] moderate 146 (7.2%) O [4] severe 43 (2.1%)
O [5] very severe 6 (.3%) O [6] worst 4 (.2%)
O [7]Unable to determine 363 (17.9%)

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.)

O [1] no pain 1062 (52.3%) O [2] mild 113 (5.6%)
O [3] moderate 113 (5.6%) O [4] severe 35 (1.7%)
O [5] very severe 12 (.6%) O [6] worst 9 (.4%)
O [7]Unable to determine 687 (33.8%)

5.3* Is an observational pain assessment tool (e.g., PAINAD, ADD, or Abbey Pain Scale) being used to assess the resident's pain?

O [1] Yes 885 (43.6%) O [2] No 1146 (56.4%)

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.)

O [1] Yes 800 (39.4%) O [2] No 126 (6.2%) O [8] Not Applicable 1105 (54.4%)

5.5* Is a <u>validated</u> 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)

O [1] Yes 1289 (63.5%) O [2] No 742 (36.5%)

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.)

O [1] Yes 1176 (57.9%) O [2] No 133 (6.5%) O [8] Not Applicable 722 (35.5%)

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.)

O [1] Yes 1495 (73.6%) O [2] No 93 (4.6%)
O [3] Unable to determine 443 (21.8%)

5.8* Does the MDS Section J 2 a. accurately reflect the resident's pain symptoms?

O [1] Yes 1855 (91.3%) O [2] No 176 (8.7%)

5.9* Does the MDS section J 2 b. accurately reflect the resident's pain intensity? (Note: *If section J 2 a. is recorded as 0, the answer is Not Applicable.)*

O [1] Yes 644 (31.7%) O [2] No 122 (6.0%) O [3] Not Applicable 1265 (62.3%)

5.10* Does the MDS section J 3. accurately reflect the resident's pain site? (Note: *If section J 2 . is recorded as 0,mark Not Applicable.)*

O [1] Yes 550 (27.1%) O [2] No 172 (8.5%) O [3] Not Applicable 1309 (64.5%)

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.)

O [1] Yes 1298 (63.9%) O [2] No 733 (36.1%)

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?

O [1] Yes 162 (8.0%) O [2] No 1869 (92.0%)

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

162 people responded to this portion of the survey

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?

O [1] Yes 71 (45.5%) O [2] No 74 (47.4%)
O [3] Transferred to ER or Hospital 10 (6.4%)

Part 7. Immunizations

All questions in this section MUST BE ANSWERED.

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

O [1] Yes 1366 (67.3%) O [2] No 665 (32.7%)

7.2* Is there <u>proper documentation</u> 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.)

O [1] Yes 676 (33.3%) O [2] No 1355 (66.7%)

7.3* Is there <u>any</u> documentation that Influenza vaccine for the 2006 Influenza Season was given? (Any form of documentation is acceptable.)

O [1] Yes 1522 (74.9%) O [2] No 509 (25.1%)

7.4* Is there <u>proper documentation</u> that Influenza vaccine for the 2006 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.)

O [1] Yes 1040 (51.2%) O [2] No 991 (48.8%)

7.5* In what month did the resident receive a 2006 Influenza Season Vaccine? (See documentation requirements in 7.1.)

O [1] Aug '06 1 (.0%)	O [2] Sep '06 28 (1.4%)	O [3] Oct '06 759 (37.4%)
O [4] Nov '06 553 (27.2%)	O [5] Dec '06 64 (3.2%)	O [6] Jan '07 20 (1.0%)
O [7] Feb ''07 11 (.5%)	O [8] Mar '07 5 (.2%)	O [9] Apr '07 1 (.0%)
O [10] May '07 8 (.4%)	O [11] Influenza Vaccine was Not Given 581 (28.6%)	

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)?

O [1] Yes 27 (1.3%) O [2] No 2004 (98.7%)

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

O [1] Yes 215 (10.6%) O [2] No 1816 (89.4%)

7.8* Does MDS section W accurately reflect the resident's influenza status?

O [1] Yes 1641 (80.8%) O [2] No 390 (19.2%)

7.9* Does MDS section W accurately reflect the resident's pneumococcal vaccine status?

O [1] Yes 1583 (77.9%) O [2] No 448 (22.1%)

Part 8. Advance Care Planning

Questions 8.1 through 8.3 MUST BE ANSWERED. Questions 8.4 and 8.5 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?

8.1a* Out of Hospital DNR (OOHDNR)
O [1] Yes 1161 (57.2%) O [2] No 870 (42.8%)

8.1b* Directive to Physicians
O [1] Yes 522 (25.7%) O [2] No 1509 (74.3%)

8.1c* Durable Medical Power of Attorney
O [1] Yes 580 (28.6%) O [2] No 1451 (71.4%)

(continued)

8.1d* DNR order
O [1] Yes 915 (45.1%) O [2] No 1116 (54.9%)

8.1e* Other intervention-limiting orders
O [1] Yes 161 (7.9%) O [2] No 1870 (92.1%)

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

O [1] Prior to admission 281 (13.8%)
O [2] Within 21 days of admission 1012 (49.8%)
O [3] Within the first 90 days of admission 76 (3.7%)
O [4] 90 or more days after admission 411 (20.2%)
O [5] Advance Care Planning <u>has not been discussed</u> with the resident or family 251 (12.4%)

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

O [1] Yes 856 (42.1%) O [2] No 1175 (57.9%)

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

1415 people responded to this portion of the survey

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?

O [1] Yes 1313 (92.8%) O [2] No 102 (7.2%)

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

O [1] Yes 1396 (98.7%) O [2] No 19 (1.3%)

8.6 Does the Advanced Care Plan address artificial nutrition and hydration?

O [1] Yes 228 (16.2%) O [2] No 1177 (83.8%)

Part 9. Tube Feeding

Question 9.1 MUST BE ANSWERED. Questions 9.2 through 9.6 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)

O [1] Yes 153 (7.5%) O [2] No 1878 (92.5%)

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

153 people responded to this portion of the survey

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)?

O [1] Yes 42 (27.5%) O [2] No 111 (72.5%)

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?

O [1] Yes 47 (30.7%) O [2] No 106 (69.3%)

9.4 Is there evidence that the resident or resident's representative provided informed consent for tube feeding? (See the Guidance. More than a form is required.)

O [1] Yes 56 (36.6%) O [2] No 97 (63.4%)

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

O [1] Yes 149 (97.4%) O [2] No 4 (2.6%)

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.)

O [1] Yes 84 (54.9%) O [2] No 46 (30.1%) O [8] Not Applicable 23 (15%)

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?

O [1] Yes 9 (5.9%) O [2] No 144 (94.1%)

Part 10. Nutrition

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.)

O [1] Yes 1882 (92.7%) O [2] No 149 (7.3%)

10.2 Does the nutritional assessment include estimating resident nutritional needs?

O [1] Yes 1808 (89.0%) O [2] No 223 (11.0%)

10.3 Have risk factors for weight loss been identified?

O [1] Yes 1320 (65.0%) O [2] No 711 (35.0%)

10.4 Is there a resident specific care plan with measurable goals that addresses weight?

O [1] Yes 1030 (50.7%) O [2] No 1001 (49.3%)

10.5 Have risk factors for the potential of dehydration been identified?

O [1] Yes 1073 (52.8%) O [2] No 958 (47.2%)

10.6 Is there a resident specific care plan with, measurable goals that addresses the potential for dehydration?

O [1] Yes 780 (38.4%) O [2] No 1251 (61.6%)

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?

O [1] Yes 142 (7.0%) O [2] No 1889 (93.0%)

11.2* Is there documentation of <u>one or more</u> anxiety symptoms characteristic of the disorder identified in 10.1? (If item 10.1 is answered NO, then answer 10.2 Not Applicable. If 10.1 is answered YES, then refer to the symptom list in the guidance.)

O [1] Yes 100 (4.9%) O [2] No 122 (6.0%) O [3] Not Applicable 1809 (89.1%)

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?

O [1] Yes 12 (.6%) O [2] No 2019 (99.4%)

11.4* Does the care plan provide explicit measurable goals for the treatment of anxiety?

O [1] Yes 138 (6.8%) O [2] No 1893 (93.2%)

11.5* Is there documentation of ongoing anxiety symptom assessment (at least every 2 weeks) for the stated, measurable therapeutic goals of anti-anxiety therapy?

O [1] Yes 53 (2.6%) O [2] No 189 (9.3%)
O [3] Not Applicable (i.e., no measurable goals) 1789 (88.1%)

11.6* Does MDS section E accurately reflect mood or behavioral symptoms or mood or behavior changes the resident has exhibited?

O [1] Yes 1899 (93.5%) O [2] No 132 (6.5%)

11.7* Does MDS section P 2. accurately reflect that the resident participated in an intervention program for mood or behavior?

O [1] Yes 1360 (67.0%) O [2] No 671 (33.0%)

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?

O [1] Yes 109 (5.4%) O [2] No 1922 (94.6%)

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)

O [1] Yes 66 (3.2%) O [2] No 1965 (96.8%)

12.3* Do the <u>last 14 days of MAR</u> show an active prescription for sleep problems?

O [1] Yes 265 (13.0%) O [2] No 1766 (87%)

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

O [1] Yes 34 (1.7%) O [2] No 1997 (98.3%)

12.5* Has the resident's sleep pattern been consistently monitored <u>during the last 14 days</u>?

O [1] Yes 529 (26.0%) O [2] No 1502 (74.0%)

Part 13. Quality of Life / Consumer Satisfaction

Questions 13.1 & 13.2 MUST BE ANSWERED. If the resident is unable to answer, then a family member or guardian may only answer item 13.17. No other individual may answer for the resident. If ANY question from 13.2 to 13.16 is answered, then EVERY question in this section must be answered.

13.1* Who is responding to this survey?

O[1] Resident 1395 (68.7%)
O[2] Family member or Guardian 309 (15.2%)
O[3] Neither 327 (16.1%)

13.2* Was a translator used for this survey?

O [1] Yes 87 (4.4%) O [2] No 1883 (95.6%)

---- If 13.1 was answered, "Family member of Guardian" then SKIP to 13.17 ----

------- If item 13.1 was answered, "Neither" then STOP --------
1395 people responded to this portion of the survey

13.3 Can you find a place to be alone when you wish?

O [1] Yes 926 (66.4%) O [2] No 352 (25.2%) O [3] No Answer 117 (8.4%)

13.4 Can you make a private phone call?

O [1] Yes 1004 (72.0%) O [2] No 257 (18.4%) O [3] No Answer 134 (9.6%)

13.5 When you have a visitor, can you find a place to visit in private?

O [1] Yes 1033 (74.1%) O [2] No 239 (17.1%) O [3] No Answer 123 (8.8%)

13.6 Can you be together in private with another resident (other than your roommate)?

O [1] Yes 718 (51.5%) O [2] No 410 (29.4%) O [3] No Answer 266 (19.1%)

13.7 Do you participate in religious activities here?

O [1] Yes 885 (63.4%) O [2] No 466 (33.4%) O [3] No Answer 44 (3.2%)

13.8 Do the religious observances here have personal meaning for you?

O [1] Yes 841 (60.3%) O [2] No 421 (30.2%) O [3] No Answer 133 (9.5%)

13.9 Do you enjoy the organized activities here at the nursing home?

O [1] Yes 877 (62.9%) O [2] No 455 (32.6%) O [3] No Answer 63 (4.5%)

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

O [1] Yes 456 (32.7%) O [2] No 787 (56.5%) O [3] No Answer 151 (10.8%)

13.11 Do you like the food here?

O [1] Yes 1044 (74.8%) O [2] No 301 (21.6%) O [3] No Answer 50 (3.6%)

13.12 Do you enjoy mealtimes here?

O [1] Yes 1123 (80.5%) O [2] No 193 (13.8%) O [3] No Answer 79 (5.7%)

13.13 Can you get your favorite foods here?

O [1] Yes 722 (51.8%) O [2] No 403 (28.9%) O [3] No Answer 270 (19.4%)

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

O [1] Yes 1050 (75.3%) O [2] No 284 (20.4%) O [3] No Answer 61 (4.4%)

13.15 Do your clothes get lost or damaged in the laundry?

O [1] Yes 442 (31.7%) O [2] No 792 (56.8%) O [3] No Answer 161 (11.5%)

13.16 Do you feel safe and secure?

O [1] Yes 1266 (90.8%) O [2] No 86 (6.2%) O [3] No Answer 43 (3.1%)

1704 people responded to this portion of the survey

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

O [1] Very Dissatisfied 37 (2.2%)
O [2] Dissatisfied 68 (4.0%)
O [3] Somewhat Dissatisfied 60 (3.5%)
O [4] Neither 38 (2.2%)
O [5] Somewhat Satisfied 211 (12.4%)
O [6] Satisfied 855 (50.2%)
O [7] Very Satisfied 424 (24.9%)
O [8] Not applicable 11 (.6%)

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

QR Nurse Signature_____ Date_____

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