Long-Term Care Survey Alert

Special Focus: Revised survey guidance--Avoid A Bitter Survey Pill: Give Your Medication And Pharmacy Services A Checkup

Use this 5-point checklist to comply with revised survey guidance.

If your head is swimming with the changes in the revised survey guidance for F329 (unnecessary medications) and pharmacy services, you're not alone. But with the guidance going into effect on Dec. 18, you need to prepare now for what surveyors will likely target on your next inspection.

Cut to the chase: Use this five-point checklist to assess where your facility needs to shore up its programs and processes.

1. Does your facility have a standardized protocol for evaluating and reporting significant medication errors to the attending physician? Under the new guidance, "low hanging fruit" for surveyors includes failure to notify the attending physician about a medication error that has a negative impact on a resident, says **Chris Puri,** an attorney with **Boult Cummings Conners & Berry** in Nashville, TN.

The guidance places more emphasis on evaluating medication errors' effect on residents as a way to determine a facility's lack of compliance -- and its scope and severity, he cautions. It also contains "more detailed emphasis on how to define a significant impact," which also includes those "likely" to affect the individual's physical or psychosocial well being, etc., he notes.

A matter of semantics: The use of the word "likely" opens the door for surveyors to exercise their judgment in handing out F tags. Puri recently grappled with an immediate jeopardy case and knows of several others where surveyors focused on "communication of medication errors to the physician and physician intervention," he says.

The problem: Attending physicians may feel inundated with reports of every single medication error that is likely to have a negative impact on a resident, says Puri.

Solutions: A facility could develop standardized protocols and formats for communicating that information to the physician -- for example, e-mail, fax or other electronic means of communication as long as it's HIPAA-compliant, says Puri. "The facility would have to get the attending physicians on board to agree to respond to the electronic transmissions -- and then monitor to see if the physicians do respond in a certain period of time." If not, the staff should involve the medical director, he adds.

Real-world practice: Facilities where **Charles Crecelius, CMD,** serves as medical director require staff to report a medication error to him immediately. Crecelius then judges whether the error warrants immediate or routine notification of the resident's attending physician.

Another potential approach: A facility could set up a system identifying the relative severity of certain medication errors and who to notify when, adds Crecelius.

2. Has your interdisciplinary team homed in on the table of "medication issues of particular relevance" in the revised F329 guidance? The table lists potentially problematic medications and related issues and concerns, including monitoring suggestions. (For a copy of the survey guidance including the table, please e-mail your request to editormon@aol.com.)

Example: Warfarin (Coumadin) is not only listed in the table but it is also "the first example in every severity citation

scenario in the guidance," says Crecelius.

Real-world practice: To monitor a resident receiving Coumadin, facilities can use flow sheets that provide a "graphic representation of dose versus response over time," Crecelius explains. Nurses using the form list the resident's Coumadin dose and the dates of protime draws and INR values. That way, the clinical team can easily "see whether the person is trending up or down." For example, if the INR value is "1" on one day and "2" on the next -- even though "2" is still within the normal range -- you know that person's INR values are shooting up fast, says Crecelius. And that resident probably needs a dosage adjustment before he gets into trouble, he adds (see the form in this issue).

The Coumadin form also lists the ranges of INR values and directs nurses to contact the physician if the patient has any bleeding symptom regardless of the INR value.

3. Are you taking steps to address the guidelines' greater emphasis on documentation requirements? "The new guidance puts so much more focus on documentation that facilities need to find ways to ensure physicians are documenting their response to medication review and decision-making about medication use," advises **Christine Twombly, RN,** a consultant with **Reingruber & Company** in St. Petersburg, FL.

Resident taking an antipsychotic med? At a minimum, assess and document the resident's behavioral symptoms and "what investigation" the facility did to find the cause of those symptoms -- and the effect of any interventions, including non-pharmacological and pharmacological ones, advises **Daniel Haimowitz, CMD,** in Levittown, PA. (For tips on assessing the root cause of residents' behaviors and using non-pharmacological interventions, see the article in this issue.)

4. Does your facility audit its pharmacy providers as part of quality assurance? Audit to see if the pharmacy dispenses medications correctly and the consultant pharmacist does the drug regimen review adequately, advises Puri.

"A lot of facilities turn that over to the pharmacy lock, stock and barrel," he observes. And while "the vast majority of the time," the pharmacy and consultant pharmacist do their jobs "perfectly well," the facility has to show that it knows what's going on, Puri says.

Headache-saving tip: Also look at whether the facility checks its incoming stock properly before sticking it on the medication cart. "Other- wise, you could have what appears to be a missing controlled substance that may not have been delivered by the pharmacy," warns Puri.

5. Does the facility do medication regimen review for short-stay residents? Under the revised guidance, facilities may need to develop ways to involve the consultant pharmacist in more than monthly reviews, suggests **William Simonson, PharmD, FASCP, CGP,** chair, **Commission for Certification in Geriatric Pharmacy.**

For example, "facilities might develop some protocols for reviewing short-stay residents," he suggests. "Many of these patients have medication issues, such as low molecular weight heparin and anticoagulation protocols that need monitoring," advises Simonson.