Long-Term Care Survey Alert

Survey Management: Don't Let Emergent-Care Shortfalls Turn Your Next Survey Into A 911

6 strategies to keep your acute-care management on track.

When it comes to meeting residents' emergent care needs, the buck stops with your facility - and so do the F tags.

Nursing facilities are seeing more citations for not handling residents' acute medical conditions properly, warn medical and legal experts. The classic example: A resident complains of chest pain or stroke symptoms but the nurse dials the doctor instead of 911.

But following doctors' orders to sit tight on a resident's condition won't get you off the hook if a resident suffers a negative outcome. For example, say a patient complains of dizziness five times, and the nurse records the symptom in the medical record and notifies the doctor each time, posits **Scott Rifkin, MD**, with **Rifkin Medical Services** in Owings Mills, MD. But the doctor doesn't order a work-up.

The resident then has a sixth episode of dizziness and drops dead from what turns out to be an unevaluated heart arrhythmia. In that case, "the facility is looking at least a G-level deficiency - and if it reflects a systemic problem, surveyors might cite immediate jeopardy," Rifkin cautions.

Arlington, VA attorney **Joseph Bianculli** reports, in fact, seeing more IJ citations at F157. That tag requires facilities to notify the physician when:

1. the resident has been injured in an accident requiring potential physician intervention; or
2. the resident has had a significant change in physical, mental or psychosocial status.

6 Strategies to Cover the Bases

Your facility needs a plan to identify and manage residents' acute-care needs - with or without the attending physician. These six strategies should put you on the right track:

1. Revisit your 911 policy to see if it provides clear direction about what constitutes an emergency. Make sure to place perfusion problems at the top of the list. "These include a change in skin color, a drastic change in heart rate or irregular heart beat, and/or acute mental status changes (even in a resident with dementia)," observes **Shelley Cohen, RN, CEN,** a certified emergency nurse and consultant in Howenwald, TN.

Also include atypical signs and symptoms of emergent conditions. "Nurses need to learn atypical presentations of conditions, such as myocardial infarction, stroke, dissecting aneurysm and sepsis," Cohen emphasizes. Facilities must counter the myth that people experiencing myocardial infarction always have chest pain - or that someone whose stroke symptoms resolve couldn't have had a stroke.

"Facilities also need a policy about how to handle situations where a family member or responsible party demands the resident be sent to the hospital," suggests **Jan Zacny**, a nursing consultant with **BKD Inc.** in Springfield, MO.

2. Inservice nursing staff regularly on acute-care triage and management. An educational strategy not only

increases nurses' acute-care prowess - it improves their confidence in knowing when to challenge attending physicians' decisions to sit on a worsening condition, notes **Beth Alford, RN**, principal of **Professional Liability Insurance Services** in Belton, MO.

Invite the local nursing instructor to come in and review lung sounds and the signs and symptoms of various acute conditions common to the elderly, Alford suggests. Or do a "swap out" with the hospital where your staff provides educational sessions on behavior management and pressure ulcers, and the hospital nurses share their acute-care assessment and triaging skills.

Focus the continuing education on helping nursing staff recognize a constellation of symptoms that warrants immediate medical intervention, advises **Beth Klitch**, president of **Survey Solutions Inc.** in Columbus, OH. One common scenario you don't want to overlook: A resident with dropping blood pressure, bruising and elevated INRs on lab reports, which signal internal bleeding due to Coumadin overdosing.

3. Implement a "hot rack" system and 24-hour report book. Using this method, any caregiver with a concern about a resident's condition can put the resident's chart in the "hot rack." The charge nurse then records the staff person's concerns and observations in the 24-hour report book for further assessment and follow-up. "The resident whose chart is in the hot rack gets assessed and charted on at least each shift," Alford says. "And anyone can put the chart in the hot rack, but only the DON decides when a resident's chart no longer needs to be there."

Tap This Hidden Asset: Solicit input each shift from CNAs who know residents best. One study showed that frontline staff often intuitively "knew" when a resident was getting ill - often days before he developed objective symptoms.

4. Don't rely on the ER for non-emergent conditions that the long-term care physician isn't addressing. "The ER isn't always the answer unless the resident has an acute symptom that needs emergent care, such as chest pain or signs of a stroke, etc.," Rifkin cautions. In fact, sending residents to the ER for chronic symptoms can turn into a revolving cycle of not resolving a resident's problem, he says. "The ER won't deal with a symptom that is occurring chronically, such as dizziness. Most likely, the resident will get tagged with dizziness of unknown etiology, and he will come right back to the facility. But then staff assumes falsely that the problem has been addressed when it hasn't," Rifkin notes.

5. Develop policies/procedures to bypass attending physicians who don't respond appropriately to a resident's symptoms. What is the solution to physicians who march to the beat of a different drummer - one that doesn't adhere to standards of care? A medical director who can write orders in the chart and who is empowered to discipline attending physicians if needed, Rifkin says. "And you want protocols in place to teach nursing staff when to call the medical director and how to respond to a lack of responsiveness on the doctor's part."

What if the medical director is the attending physician who's not dealing with what the nurse views as an emergent condition? "The nurse can send the patient to the ER if she feels the patient needs emergent care," Klitch emphasizes. "That's not second-guessing the physician - it's responding to an acute emergency and ensuring that the resident gets that third or fourth opinion and access to lifesaving drugs and expert diagnosis of acute conditions."

6. Implement assessment protocols to detect changes in pain and mental status that could indicate a serious acute physical condition. For example, Alford once noticed a resident in the dining room who wasn't eating and appeared reluctant to use her fork. When asked, the resident confided that her arm hurt too much to use her fork. Turns out the woman had fractured her arm four days earlier and had been complaining of arm pain the entire time. But the nurses hadn't caught on because the resident often said her arm hurt.

Lesson Learned: Get a good baseline pain assessment so you can identify when a resident's pain increases or changes in nature. "A description of 'arm pain' is too vague to be able to detect a change in the type and potential cause of pain (for example, due to arthritis versus a fracture)," Alford says.

Also watch for changes in behavior in dementia residents that may signal an injury or painful condition. "For example, if a resident with dementia falls and subsequently becomes more agitated, aggressive or refuses to get out of bed,

consider that he might have an undetected injury," advises **Joanne Rader, RN, MN, FAAN**, associate professor of nursing at **Oregon Health Sciences University School of Nursing** in Portland.

Clinical Gems: Flag residents with osteoporosis so you can watch them for signs of fracture (limping, guarding a limb, unwillingness to move, change in behaviors, signs of pain).

Use the delirium Resident Assessment Protocol (RAP) key to assess residents with mental status changes that may portend a life-threatening condition, such as infection, or a subdural hematoma from an unobserved fall.