Long-Term Care Survey Alert

Survey Management: Don't Let Residents Flagging On The Low-Risk Pressure Ulcer QI/QM Heighten F-Tag Risk

How to analyze residents experiencing this sentinel event.

Scenario: A facility's latest QI/QM report identifies residents with low-risk pressure ulcers. Even worse, the facility is in its survey window. Now what?

Knowing how the QI/QM works and what to do when a resident triggers it will help you sidestep F314 and other deficiencies and lawsuits.

Nail down the risk factors: The high-risk pressure ulcer QI/QM includes residents coded on the MDS as requiring extensive assistance, total dependence or activity did not occur (codes of 3, 4 or 8) for bed mobility or transfer or those coded as being comatose (B1 = 1) or as having specific ICD-9-CM codes for malnutrition in Section I3.

Everyone else with a pressure ulcer on the target assessment who doesn't meet the definition for high risk goes into the denominator for the low-risk chronic care pressure ulcer QI/QM, said **Christie Teigland, PhD**, in a presentation **at** the **American Medical Directors Association** annual meeting in March 2007. That's true whether the person has one stage 1 or several stage 4s, Teigland said.

Check before submitting the MDS to the state: Some facilities recheck ADL scores for someone who flags as having a low-risk pressure ulcer," **Patricia Boyer, RN**, principal of **Boyer and Associates** in Brookfield, WI, tells **Eli.**

Also make sure you've coded malnutrition in Section I3 of the MDS, if the resident has the condition.

The problem: Teigland noted that she looks at hundreds of MDSs yet hardly ever sees malnutrition coded. She has also had clinicians from facilities call to say they have residents with malnutrition and pressure ulcers who don't show up as low risk. In such cases, the facility isn't coding the malnutrition using the specified ICD-9-CM codes. (See the codes at http://www.qtso.com/download/mds/qiqm_rpt/Appendix_A_Technical_Specs.pdf.)

Solution: Facilities have to identify residents losing weight and identify what the clinician thinks is causing the weight loss, urged **Cornelius J. Foley, MD**, a medical director from New York who copresented with Teigland at the AMDA conference. He reported that his facility has had patients with cachexia or sarcopenia, which are not infrequent conditions. But unless the physician documents malnutrition in the medical record, the MDS team can't capture that information on the MDS. Thus, the physician has to put the diagnosis in the chart, he emphasized.

Identify, Document the Resident's True Risk Factors

Given that the low-risk QI/QM defines who's at low risk so narrowly, the staff needs to identify, document and address a resident's known risk factors for developing a pressure ulcer.

Rely on the RAP: If a resident triggers the pressure ulcer RAP, the staff looks at a bunch of risk factors that aren't included in the chronic care QI/QM, noted Teigland. So the RAP recognizes that those factors need to be reviewed and care planned, even though the CMS QI/QM does not. The F314 investigative survey protocol adds a lot of other risk factors for pressure ulcers, noted Teigland. And if surveyors think the facility has a problem with pressure ulcers, they are going to see if the care team is addressing the risks identified by the protocol (review the risk factors at http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

Tips: Consider using standardized history and physical formats and 30-day physician progress notes that identify risk factors for pressure ulcers, suggested Foley. Those types of formats cue the physician to identify and document whether potential risk factors for pressure ulcers exist.

Also look at all of the QIs/QMs a resident with a pressure ulcer triggers. "You can't address each adverse outcome in a vacuum," Teigland stressed. For example, you may see a resident with a pressure ulcer has also flagged on falls, nine or more medications, a catheter, frequent incontinence without a toileting plan, weight loss and pain, she noted.

Explain Impact of Aggressive Skin Assessment

Consider this: Facilities that are more diligent about coding stage 1 pressure ulcers are going to look worse on the chronic care pressure ulcer QI/QMs. But hopefully they won't end up with a lot of residents with higher stage pressure ulcers, the presenters pointed out.

If you're worried about your facility's survey performance in such a case, explain to surveyors how the facility's systems are excellent at picking up residents with stage 1 ulcers early as opposed to finding the ulcers at stage 2 or 3, Foley counseled AMDA conferees.