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# MDS Alert

## Case Study: Quality Assurance and Survey Management--Streamline Physician Summary Forms To Tackle High QIs And F501 Noncompliance

**Cue physicians to give the answers you need.**

If you're looking for a way to ensure physicians stay on top of the "hot button" clinical issues that drive the QIs/QMs and your care planning, consider making it easy for them and you--very easy.

Design a standardized monthly summary form that allows attending physicians to quickly provide information to address the resident's key clinical issues and plan of treatment.

That's what nursing facilities managed by **TSW Management Group** in California plan to do under the revised F501 survey guidance, which requires medical directors and facilities to ensure attending physicians provide appropriate care. "The standardized monthly progress note will include a half page narrative and a half page of reminders," says **Kathy Hurst, RN, JD**, director of healthcare operations for the Anaheim Hills-based company. "The reminders will include psychotropic medications (potential chemical restraints), wounds and weight loss," she adds.

The summary form will ask, for example: Did the resident have a significant weight loss with a "yes/no" option. Answering the question forces the physician and medical director to look at weight loss as defined by the RAI manual and California state law, as the latter is more stringent.

If the resident is taking a psychotropic drug, the form will ask the physician to document the drug and dosage. The physician will then explain why the benefits of the drug continue to outweigh its risks by checking off answers that include:

• improved quality of life

• hallucinations (or other psychotic symptoms) decreased

• absence of side effects

• "other" which the physician documents in narrative form.

To address wound healing and care, the form will ask if the patient has a wound (yes/no) and if yes, direct the physician to answer: Is the wound healing? Other questions ask the physician to record when he has order changes (yes/no), plans to continue ongoing therapy and why (the rationale for continuing the therapy).

Hurst believes that if the facility gives the attending physicians the right cues, they will complete the documentation. "The documentation will also help the nursing staff when they have to sit down with the medical director and say we are not having good outcomes and you need to intervene," adds Hurst.