



The Next Big Step In Quality

The Advancing Excellence in America's Nursing Homes campaign pushes quality goals beyond the level of regulatory compliance.

BACKED BY A BROAD-BASED coalition of organizations and stakeholders, the Advancing Excellence in America's Nursing Homes campaign was developed to meet the growing demand among patients, their families, and advocates for long term care facilities to achieve and sustain ever higher levels of quality care and quality of life.

The two-year voluntary initiative is designed to be a powerful catalyst in moving participating facilities toward specific goals and objectives, and it is the next level in the hierarchy of quality initiatives.

How It Works

Nursing facilities participating in Advancing Excellence (AE) strive for quality by setting measurable clinical and process goals in at least three of eight specifically defined areas (*see box, right*). In addition, the campaign builds on existing quality initiatives and acknowledges the purpose of the Centers for Medicare & Medicaid Services' (CMS') regulatory process.

AE's creators recognized that convergence with existing quality improvement initiatives and tools, such as Quality First and the Nursing Home Quality Initiative (NHQI), is as important for success as is collaboration among the organizations committed to high-quality care.

Comparison of the campaign's concepts to current quality improvement efforts reveals that AE reinforces existing tools and facilitates quality initiatives. The campaign recognizes the purpose of CMS' regulations and,

where overlap exists among various initiatives, it validates the need for facilities to use a variety of approaches to achieve a goal. For example, restraint use and high-risk pressure ulcers are performance areas in both the NHQI and AE campaigns, and

Advancing Excellence: The Eight Core Goals

1. Preventing and minimizing pressure ulcers
2. Reducing restraint use
3. Reducing pain in long-stay residents
4. Reducing post-acute care pain
5. Setting clinical targets
6. Achieving resident and family satisfaction
7. Reducing nursing staff turnover
8. Employing consistent assignment of staff to patients

Source: Advancing Excellence in America's Nursing Homes



each area is governed by a CMS regulation. Staff retention and customer satisfaction comprise performance goals in all three.

Regulation is necessary but not sufficient for high-quality care. This is one of the conclusions in the 1983 Institute of Medicine report that led to the

landmark reforms of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). Although OBRA '87 is credited with improving patients' quality of care and quality of life—by, for example, mandating a reduction in the use of physical restraints and a stronger emphasis on residents' rights—long term care professionals, consumer advocates, and government officials continue to view regulatory compliance as only one step among many that are needed to achieve and sustain higher levels of quality.

Therefore, the combination of Quality First core principles and Advancing Excellence goals and objectives, as well as other initiatives such as the NHQI and the culture change movement, when meshed with regulatory compliance, enable facilities to achieve the type of care and outcomes that individuals who are elderly, frail, or have disabilities expect and can depend on to meet their needs.

Survey Requirements

All Medicare/Medicaid-certified facilities must meet CMS' regulatory compliance criteria. Those that deliver quality care achieve and sustain compliance based on their performance and patient outcomes. Rules and

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guidance generally fall into three categories:

- *Clinical protocols* (assessment, individualized interventions, care planning, communication, documentation, and reassessment);

- *Quality-of-life issues* (person-centered care; choices and preferences honored; facility responsibility toward each patient; opportunity for patients to learn and grow; and acknowledgment of each patient's strengths, gifts, and contributions); and

- *Management/operations* (medical direction, improved compliance with regulations, and improvement in clinical outcomes and CMS' quality measures).

These categories parallel the goals and performance expectations of Quality First and Advancing Excellence.

To encourage facilities' performance,

CMS incorporates facility processes into much of the guidance that accompanies each regulation. The agency expects facilities to employ certain processes, including risk assessment and achievement of expected outcomes. In addition, CMS expects that facilities' performance will be systems-driven (including assessment, individualized interventions, care planning, communication, documentation, and reassessment). AE and Quality First are also systems-driven in that they recognize that the elements of quality care and quality of life are interrelated and that a failure in one part of the system can jeopardize the entire level of quality in a facility.

Beyond Regulatory Compliance

One of the key concepts underlying AE is that regulatory compliance is not enough to achieve or sustain quality.

Regulations define expectations to achieve specific goals (prevention of avoidable pressure ulcers, for example), and, as such, they are a starting point—not an end point—for quality. This means that facilities need to go further in assessing, planning, and delivering care and take steps that are broader than simply complying with CMS' regulations.

For example, reducing the incidence of high-risk pressure ulcers, limiting daily use of physical restraints, and improving pain management are goals related to CMS regulations. All have direct connections to patient assessment and care planning. There are specific regulations governing pressure ulcers (F314) and restraints (F221), and unnecessary drugs (F329) or medication regimen review (F428) apply to pain management. Complying with these regulations does not necessarily mean that a facility will achieve the highest levels of quality possible.

Achieving excellence in care is not just about nonuse of restraints or using them only within the confines of the regulation, and it is not just related to preventing pressure ulcers. Excellence is about proactively identifying patients' risks, assessing needs, and providing options to restraints or methods to prevent pressure ulcers to meet clinical outcomes and ensure safety. It is about working with pharmacists and physicians to develop facility policies and implement procedures. And it is about enhancing patients' quality of life through specific steps (activities, communication, inclusion, and viewing the patient as a person, for example).

Achieving Process Goals

Clinical quality improvement, resident and family satisfaction, staff retention and turnover, and consistent assignment of staff to patients comprise AE's process-oriented goals. The goals are connected to a range of CMS regulations rather than a specific CMS requirement. For example, F520, qual-

ity assessment and assurance (QAA), defines the composition and functions of facilities' QAA committees. It provides a platform for the facility's clinical quality improvement efforts and movement toward excellence.

Regulatory compliance alone, however, does not ensure that patients will be satisfied with their experiences or lives in the facility. How the facility complies with patients' rights requirements, such as the right to make decisions about life and care in the facility (F150 and F242), voice grievances (F165), and participate in care planning (F280) is likely to determine patients' life experiences. Whether the facility merely meets the basic requirements for activities under F248 or incorporates the principles of person-centered care will significantly influence patients' attitudes and responses.

For example, collecting information from patients and their families without acting on the information is not enough to ensure excellence. Facilities need to involve patients and families to a greater extent in order to determine the nature of each patient's experiences and level of satisfaction with care and life in the facility.

Facilities need to reach higher and greater levels to achieve excellence. How and whether the facility advances quality of care and life by encouraging staff-to-resident relationships (employing consistent staff assignments and reducing the rate of staff turnover, for example) goes a long way beyond minimal requirements and helps the facility move toward achieving excellence.

If facilities mesh or blend Quality First core principles with regulatory compliance, they become empowered to achieve the care and outcomes that their patients expect and need. Participation in Advancing Excellence in America's Nursing Homes is a facility's acknowledgement that the processes and practices it incorporates will be instrumental in achieving targeted outcomes and performance levels. ■



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Panel Updates Pressure Ulcer Descriptions

The National Pressure Ulcer Advisory Panel (NPUAP) recently released revised descriptions for the identification of pressure ulcer stages, replacing the 1987 and 1993 versions.

While encouraging institutions to

include these new definitions in their decision making and documentation, the panel noted the original definitions were confusing to many clinicians, leading to “inaccurate staging of ulcers associated with or due to perineal der-

matitis and those due to deep-tissue injury.”

The original four stages and an additional two stages on deep-tissue injury and unstageable pressure ulcers were included in the revisions, along with the definitions of stages I, II, III, and IV, which were updated to improve the accuracy of diagnosing pressure ulcers and differentiate pressure ulcers from other skin lesions.

NPUAP now defines a pressure ulcer as, “A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.”

Following are the panel’s revised stages and descriptions:

- *Suspected deep tissue injury.* A purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler compared to adjacent tissue.

Deep tissue injury may be difficult to detect in individuals with dark skin tones, NPUAP says. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.

- *Stage I.* A localized area of intact skin with nonblanchable redness, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer, or cooler when compared with adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones.

- *Stage II.* Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as ➤

an intact or open/ruptured serum-filled blister.

Presents as a shiny or dry shallow ulcer without slough or bruising. This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration, or excoriation. Bruising indicates suspected deep tissue injury.

■ *Stage III.* Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. It may include undermining and tunneling.

The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

■ *Stage IV.* Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (fascia, tendon, or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

■ *Unstageable.* Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth and, therefore, stage cannot be determined. Stable (dry, adherent, intact without erythema

or fluctuance) eschar on the heels serves as “the body’s natural [biological] cover” and should not be removed.

Upon release of the new descriptions, NPUAP stressed the importance of using the staging system only to describe pressure ulcers. “Wounds from other causes, such as arterial,

venous, diabetic foot, skin tears, tape burns, perineal dermatitis, maceration, or excoriation should not be staged using this system,” the panel said, suggesting that other existing staging systems “for some of these conditions” be used instead.

—Meg LaPorte