# Long-Term Care Survey Alert

## Risk Management: Never Say Hospital 'Never Events' Can't Come Back To Haunt Your SNF

Here's what you need to know and do now.

If Medicare's no-payment policy for a list of "never events" isn't on your risk-management radar screen, your SNF may be more vulnerable to liability and survey problems than you realize.

Mark your calendars: Starting Oct. 1, Medicare won't pay hospitals for the extra costs of numerous hospital-acquired conditions, including stage 3 and 4 pressure ulcers and catheter-associated urinary tract infections (see the list on p. 74). And nursing homes need to be prepared for the "collateral consequences" of hospitals more thoroughly documenting patients' conditions at admission to the hospital, says attorney **Paula Sanders**, a partner with **Post & Schell** in Harrisburg, PA.

What to watch out for: "The resident could potentially return with hospital admission diagnoses that make it look like the person developed the condition in the SNF prior to hospital admission," Sanders says. And with survey scrutiny of nursing homes, and Recovery Audit Contractors out there doing audits, this could be a problem, she cautions.

Target These 2 Areas of Vulnerability

1. Transfer Documentation. A one-page transfer sheet with minimal information about the resident's condition when he's transferred to the hospital isn't going to be sufficient, cautions Sanders.

Instead: The transfer documentation should not only describe the rationale for the resident's hospitalization but also describe the resident's condition at transfer, the disposition of the person's medications and belongings -- and any conversations the facility had with physicians or other providers, including the resident's family, says **Marilyn Mines, RN, RAC-CT, BC**, manager of clinical services for **FR&R Healthcare Consulting Inc**. in Deerfield, IL.

Reduce variation: Consider standardizing "hand-offs" of residents from the nursing home to the hospital. "Using specific forms and checklists can help in that process," suggests **Peter Angood, MD**, VP and chief patient safety officer for the **Joint Commission**, in discussing accreditation requirements that can improve risk management in all facilities. "Depending on the patient's acuity at the time of transfer, providing direct verbal communication with the hand-off is optimal," although admittedly not always possible, he says. The transfer documentation should include phone numbers or ways to contact the nursing home to clarify information about the patient's status.

**2. Pressure Ulcers.** Pressure ulcers are the "never event" that concerns geriatric legal nurse consultant and nurse practitioner **Mardy Chizek** the most. Why so? She has seen nursing home residents with intact skin go to the hospital and return four days later with several stage 3 pressure ulcers. Or the physician in the hospital may have diagnosed a non-pressure-related lesion as a pressure ulcer, she adds.

To address these potential problems, nursing staff should do a head-to-toe assessment when the resident is getting ready to be transferred to the hospital, as well as when she returns, and document findings, Mines advises. Be on the lookout for signs of deep tissue injury, which can open up into a serious pressure ulcer in a few days. "The pressure event that can cause a pressure ulcer in a short period of time may create something that appears insignificant in the minds of assessors," says **Bruce Robinson, MD**, chief of geriatrics at **Sarasota Memorial Hospital** in Sarasota, FL. For example, the person may have what appears to be a bruised area on the sacrum, he says. The area of discoloration may be hard to detect in a person with dark skin tone, according to the **National Pressure Ulcer Advisory Panel**. "The

area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue," states the NPUAP in a statement about its revised guidelines for staging pressure ulcers.

Avoid this common mistake: Never assume a skin lesion is a pressure ulcer and document it as such. For example, "if the resident is a diabetic with longstanding neuropathy and the lesion is not on a bony prominence -- or even if it is -- the lesion may not be related to pressure but rather to poor vascular flow and diabetes," says Chizek, principal of **Chizek Consulting Inc.** in Westmont, IL. Having the physician or physician extender use accepted guidelines to diagnose a skin lesion helps prevent the facility from taking the rap for non-pressure related wounds. And it helps the care team select the correct protocols to heal the wound.

Collaborate With the Hospital

Consider having the SNF quality assurance committee develop a working relationship with the hospital QA committee, suggests **Marty Pachciarz, RN, RAC-CT**, a clinical consultant with the **Polaris Group** in Tampa, FL. If the SNF refers a concern to the hospital about a case -- or multiple cases over time demonstrating a negative trend -- most hospitals will investigate the issues, she notes.

First steps: Ask to meet the hospital's key QA members and develop a relationship that includes the SNF's medical director, advises Pachciarz. Issues that the hospital and SNF could address collaboratively include the following, she suggests:

• Residents who die within 24 hours of admission from the hospital to the SNF;

• A hospital readmission within 48 hours of admission to the SNF;

• Pressure ulcers/deep tissue compromise upon admission or within three days or so after SNF admission. "The hospital may be able to track [the pressure ulcer] back to a certain unit in the hospital," says Pachciarz.

• Infections, especially ones involving a super bug, that occur within a certain time frame after a resident's admission to the SNF from the hospital.