Issue 2– Winter 2024

LIFE
LIVING INDEPENDENCE FOR THE ELDERLY
Serving Armstrong, Beaver, Butler and Lawrence Counties

QUALITY NEWSLETTER

LIFE Armstrong, Beaver, Butler and Lawrence

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- Falls Prevention
- Center success story
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- Survey Readiness
- CMS ongoing measures
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What is my role in Quality?

- All LIFE staff are vital to quality.
- Documentation is an essential quality element because if something is not documented, it is considered not done.

Example: Transportation

- Was the attendance documented?
- Did the paperwork from a consult appointment get back to the center?
- If documentation is not there, the appointment did not exist.

Falls Initiative:

- IDT Falls Committee developed due to increase in multiple falls, which directly increases fall rate & likelihood of serious injury.
- Committee meets quarterly to evaluate fall assessment & prevention opportunities for improvement.
- CDC STEADI (Stopping Eldering Accidents, Deaths and Injuries) program being trialed in Armstrong beginning October 2023.
- Next meeting in March 2024

"Quality is everyone's responsibility."

W. Edwards Deming

Centers Success Story

All centers were below the pressure wound rate of < 5 wounds per 1000 participant days for the Oct-Dec 2023 quarter.

Great job to all IDT staff for quick interventions and proactive assessment and monitoring of skin areas

What is a Service Determination Request?

When a participant or authorized representative/ caregiver asks for:

- new service (e.g., home care)
- change or modify a current service
- discontinue a service
- continue s service IDT recommends be discontinued

Please submit any questions to Laura Hankey, Denise Pia or Elizabeth Bauer and these can be added to the next edition

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CMS Regulation Highlight/Survey Readiness:

Documentation is directly related to CMS regulations and are the most common findings in our recent surveys.

42 CFR § 460.98 - SERVICE DELIVERY
Provision of services.

PACE Organization must document, track and monitor provision of services across all care settings to ensure the IDT remains alert to participant's medical, physical, emotional, and social needs.

Examples:

IDT Assessments
Care Plan
Ordered testing (i.e., labs, x-rays)
Consults
Home & Wound Care
PT/OT
Hospitalization/ER Visits
SNF/ECF care

42 CFR § 460.210 MEDICAL RECORDS

At a minimum, the medical record must contain the following:

Documentation of all services including:
- Summary of ER & other inpatient or long-term services
- Services furnished by employees of PACE
- Services furnished by contractors & their reports

IDT reassessments, plans of care, treatment, and progress notes that include the participant's response to treatment.

All recommendations for services made by employees or contractors of the PACE Organization, including specialists.

Beaver/Lawrence CMS Survey Ongoing Measures

Survey Finding	Items to Address
Service Determination Requests	All IDT members must sign attended meeting when approving or deny request
Lab Review	Ensure lab results are received and scanned into medical record
Consult Review	Ensure consult recommendations are received and scanned into medical record.
Wound documentation	Ensure all wound care is documented per physician order
Home Care Sheet	Ensure Home Care documentation matches what is on the care plan
Discharge Summaries	SNF & Hospital admission/discharge and LTC documentation reviewed and care plan updated to reflect any new changes.
New Medication List	Medication list is updated after each hospital/SNF discharge

OLTL Environmental Survey Findings

Survey Finding	Action Plan
Sharps containers overfilled	• Check for fullness • Container should not be over flowing & changed when sharps reach line denoting it is full.
Disrepair & cleaning of center showers	• Monitor areas needing repair and cleanliness.
Glucometers	• All centers must use multi-use glucometers per manufacturer guidelines. • Policy updated regarding glucometer use.