Survey Deficiencies Are Not Reliable for Drawing Conclusions About Aspects of Quality

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This issue of the Journal includes a study by Lerner et al seeking to identify any correlations between survey deficiencies and Certified Nursing Assistant (CNA) and Registered Nurse or Licensed Practical Nurse turnover in nursing homes. The study selected Online Survey Certification and Reporting deficiencies from the Quality of Care, Quality of Life and Resident Behavior categories, which were considered to be more closely related to nursing care.

The study concludes that high CNA turnover was associated with high numbers of Quality of Care, resident behavior, and total selected deficiencies, and that licensed nurse turnover was significantly related to Quality of Care deficiencies and total selected deficiencies. When both CNA turnover and licensed nurse turnover were included in the same model, high licensed nurse turnover was significantly associated with Quality of Care and total deficiencies whereas CNA turnover was not associated with that category of deficiencies.

The study’s authors conclude that turnover in nursing homes for both licensed staff and CNA staff is associated with quality problems as measured by deficiencies. They suggest that more efforts to retain nursing staff are needed.

The primary basis for these conclusions is the number of survey deficiencies in various categories. Other studies have also used survey deficiencies as a basis for drawing conclusions; for example, the impact of certified medical directors on facilities. Certain criteria must be met if survey deficiencies are to be a meaningful basis for drawing any conclusions about care, including (1) the survey process promotes review of all important aspects of care, or there is evidence that the subset that is reviewed adequately represents all important care aspects; (2) surveyors consistently follow survey protocols and guidelines, which give them clear and consistent criteria for determining compliance; (3) survey protocols and guidelines provide an adequate basis for evaluating related performance and practice; (4) surveyors uniformly apply compliance criteria across facilities and residents/patients; and (5) surveyors consistently and correctly identify compliance and instances of noncompliance. However, for many reasons, none of the above is true.

First, the survey process does not cover all important aspects of care. According to the American Health Care Association, the average 100-bed nursing home will serve 189 individuals a year for short-stay, postacute care vs approximately 86 long term care residents. Although the focus of nursing home care is increasingly on short-stay patients, and also on managing health issues for long-term residents, the 1987 Omnibus Budget Reconciliation Act (OBRA ’87) regulatory requirements lean primarily toward psychosocial, functional, behavioral, and quality of life issues for long-term residents.

The Omnibus Budget Reconciliation Act regulations include approximately 180 F-Tags (areas for compliance). Approximately 18 of these Tags cover quality of life and 21 of them cover quality of care (eg, nutrition, hydration, falls). Although many of the regulations are relevant to both long-term residents and short-stay patients, they also omit or minimize many key aspects of care.

Furthermore, surveyors do not review the same aspects of care to the same extent. They often look only for certain things, avoid medically complex patients, and often lack enough guidance from the State Operations Manual to determine accurately whether facility staff and practitioners correctly defined issues and identified and managed underlying causes.

A “deficiency” means a conclusion, based on weighing all relevant evidence, that a facility failed to comply with a provision of the federal requirements for participation as a nursing facility in the Medicare/Medicaid programs, typically because of a deficient practice that either was the likely cause of a negative outcome or was likely to lead to a negative outcome even though one did not occur. Because the survey process focuses surveyors on compliance with regulations, surveyors may not even ask all the questions they need to.

For example, delirium is a medical illness of acute or subacute onset, requiring urgent attention, that commonly presents with behavior and psychiatric symptoms, disturbances of consciousness and attention, cognitive changes (eg, thought and memory) and/or perceptual impairments (illusions, hallucinations, or delusions). It is common in both the hospital and the nursing home, and it increases the risk for short- and longer-term complications (eg, dementia, pressure ulcers, pneumonia, rehospitalization, slower post-hospitalization recovery) and death.

Recognizing the presence of delirium requires a high index of suspicion and a coordinated effort among health care practitioners, nurses, and other direct care staff. It should be considered in any patient who has a change in behavior or mental function, regardless of whether they also have dementia.

The advisors to the Centers for Medicare and Medicaid Services (CMS) considered delirium to be important enough to incorporate a valid screening instrument—the Confusion Assessment Method—into
the Minimum Data Set, Version 3.0. In addition, “delirium” is a key potential trigger for care planning that may appear after completing the Minimum Data Set.

A meaningful survey process would routinely review for whether and how facilities evaluate and manage individuals who are at risk for, or who have triggered for delirium, including those with altered mental status, behavior issues, short-term cognitive and functional decline, and who are placed on any category of psychopharmacologic medications. Surveyors would apply comparable criteria uniformly to identify whether staff and practitioners identified and addressed delirium appropriately, recognize when individuals may have had negative outcomes related to failure to do so, and apply consistent criteria to evaluate whether these facility practices are somehow linked to resident outcomes.

However, surveyors only sometimes correctly determine deficiencies, especially in more complex cases, and appropriately link facility practices to resident outcomes. Although facilities may complain with some justification that surveyors sometimes incorrectly make such connections, surveyors often fail to recognize situations where cause identification (eg, recognition of delirium) is incorrect and subsequent interventions are inappropriate or problematic. Despite detailed guidance in F329 (unnecessary medications), surveyors often do not recognize facility failure to identify and address common and troubling medication-related adverse consequences that result in serious negative outcomes including delirium; for example, anticholinergic medications used to treat incontinence or falls and psychiatric symptoms due to anti-Parkinson medications, antidepressants, and medications used to treat cardiac arrhythmias.

In addition, surveyor willingness and ability to do a thorough and accurate investigation is often limited by predispositions. Like nurses and health care practitioners, surveyors often have “anchoring bias;” that is, their minds are already made up before they even start the survey or soon after they see certain diagnoses, treatments, or outcomes for residents/patients. For example, the scope of review may be limited because names of residents/patients to review are already selected, based on a facility’s quality indicator results, before the survey starts.

The Quality Indicator Survey (QIS), which is being used by only some surveyors in some states, differs from the traditional survey. It has only been partially implemented nationally, it focuses greatly on resident rights and quality of life and relatively little on quality of care, and many of its questions are tightly structured and leave little room for surveyors to go down additional paths of inquiry that may be identified through a more flexible approach.

For instance, surveyors may be predisposed to misunderstand or overlook inappropriate pain management, such as inappropriate use of opioids or continued use despite causing serious adverse consequences, because of erroneous “conventional wisdom” such as “pain is totally subjective” or “everyone has the right to be largely free of pain.” Or, they may overlook inadequate guesswork about whether nonspecific symptoms in individuals with dementia actually indicate pain or unnecessary use of high-risk analgesics due to inadequate assessment and diagnosis. Surveyors may not identify when staff and practitioners fail to seek enough details about pain symptoms and instead choose interventions based on vague information and excessive speculation about causes.

Because of inadequate understanding about the correct diagnosis of depression, belief in myths about treatment of depression, and belief that treating even isolated symptoms of depression is desirable, surveyors may be predisposed to accept treatment even when it is not indicated. For example, “demoralization” is not depression and usually should not be treated with antidepressants, and antidepressants are known to cause significant side effects such as falls, increasing restlessness, dizziness, and gastrointestinal symptoms.

Yet another example is the pressure on surveyors to scrutinize facility staffing, especially as it relates to approaches to resident/patient behavior. “Consistent assignment” is a universally praised ideal, despite its unclear definition and questionable benefits. The control variables (staffing and skill mix) for the study by Lerner et al are limited in scope. Given the aforementioned shifts in population served, traditional meanings of “skill mix” may not even be valid in contemporary long term care and their meaning may differ depending on a facility’s case mix.

Still, other factors influence the survey process and deficiency identification and citation. Surveyors are known to take different approaches to surveying facilities that present well, look nice, have a good reputation, or have higher levels of resident/patient satisfaction, compared with facilities that are less attractive, already have issues identified from previous surveys, or are less cooperative. It is not unusual, however, for surveyors to scrutinize less thoroughly facilities where they have a good relationship with the director of nursing and administrator, and thereby miss egregious care problems.

Regardless of any reasons offered for variability in surveys (eg, limited health department budgets, low surveyor salaries, inadequate time to do thorough reviews in many areas, variable surveyor knowledge and skills), ultimately surveys are often inadequate to assess quality and are not comparable within or across facilities or states. Surveyors often miss important things and may reach questionable conclusions. For example, experience and the literature strongly suggests that the number of unidentified and inadequately managed serious medication-related adverse consequences far exceeds the number of citations for F329 (unnecessary medications).

While Lerner et al discuss superficially the purpose of the survey and the notion of deficiencies, they do not appear to acknowledge these problems of inconsistent surveys, missed problems, and questionable interpretations. Also, they do not consider that survey deficiencies relate not just to direct care but also to care plans, orders, and other aspects of decision making and oversight that provide the foundation for the performance of direct care staff, regardless of numbers. Finally, the authors appear to have overlooked other important issues other than turnover, such as poor management, poor use of existing staff, inadequate instructions to staff, or inadequate physician diagnosis and other cause identification efforts.

In conclusion, reliance on survey deficiencies as a key indicator of quality is unwarranted and should be reconsidered. For example, key components of the CMS “Five-Star” Quality rating system include staffing and major survey deficiencies. For many reasons discussed herein, this approach is highly questionable despite its popularity among advocates, politicians, and others. As noted elsewhere, it is entirely possible that so many concerns about nursing homes still exist because the measurements are suspect and the advice given to facilities based on those measurements is often invalid.

References


