# 10 Common Myths About Survey

***A former surveyor explains how misconceptions about the survey process can distract a facility from concentrating on the real issues at hand.***

THE STANDARD LONG TERM CARE survey is often perceived as an enigma. It's a 40- to 50-hour amalgam of impressions, observations, and analyses designed to evaluate 365 days of nonstop care, ranging from spoon-feeding to the amelioration of intractable pain. It mandates a handful of specialists to become intimately familiar with the daily lives of dozens of strangers, heretofore known only by the check marks on a short list of clinical indicators or a certified nurse assistant assignment sheet. It is the most opportune occasion for a facility to show off its best and brightest. Yet for many, it's the most feared and anxiety-producing event of the year.

Unfortunately, a facility's preparation and performance during the survey are often compromised by the promulgation of myths and misinformation. These myths often arise from the fear that surveyors will be scrutinizing every move, every utterance, and, of course, every care plan intervention in search of unseen deficiencies. Though some would argue that such fears are justifiable, they have the potential to take a facility off course by sabotaging the reasonable judgment, critical-thinking activities, and performance of basic tasks that underscore good care and desired survey outcomes.

Following is a list of 10 of the most common survey misconceptions.

**1. Surveyors have to find deficiencies to keep their jobs.** In truth, citation construction (writing an F-tag) is one of the most difficult and laborious aspects of a surveyor's job. Surveyors are more than happy to determine that a facility is in compliance with any or all of the regulatory requirements. Simply put, there is no quota system for F-tags.

**2. There is a specific deficiency** that is "fashionable" this month. While the scuttlebutt may be that the health department is honing in on a specific concern, it is probably due to the fact that it was identified in a prior survey and is fresh in people's memories. Still, the primary source of information that survey teams initially work from is the Centers for Medicare & Medicaid Services' Quality Indicator profile. Other, "real-time" issues are picked up on tour, on interview, or from complaints. Occasionally, a serious incident in a neighboring facility will raise a survey team's sensitivity to that concern. But there is no protocol for surveyors to designate a "flavor of the month," clinically speaking.

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**3. Surveyors are "out to get"** certain facilities. Though long term care providers often take survey issues personally, most surveyors simply want to get the job done as quickly and accurately as possible. While individual facilities may sit on pins and needles all year waiting for the ax to fall, the survey team has probably just completed another survey two days ago, has three more to go this month, and faces mountains of paperwork back at the office. Surveyors have little time and even less inclination to engage in vendettas against individual facilities.

This myth is further perpetuated by endless discussions among staff when the survey is in progress. Phone calls abound during survey between staff members whispering cautionary warnings like, "I saw this one" "She's in the dining room now ... she snuck down the back staircase ... she looks like something's wrong ... she didn't say 'hello' to me today." Rightly or wrongly, some surveyors are frequently characterized as being indifferent, mean-spirited, or downright rude.

In reality, the tasks surveyors are required to complete require extreme concentration and discretion. These qualities demand a certain degree of professional "distance" that may be construed as unfriendliness, or worse. Generally speaking, staff impressions of surveyors are irrelevant and unimportant. Unless staff have psychic abilities, they're better off attending to patient care than

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trying to second-guess the mood of the surveyors.

**4. The squeaky wheel gets the** grease. The idea that a single irate patient will receive inordinate attention and bring the whole facility down during a survey is totally without merit. Survey teams are aware that most facilities have patients who are chronic complainers and leap at the opportunity to voice their complaints to an inspector even after Herculean attempts have been made to appease them. It is incumbent upon all surveyors to investigate any complaints or allegations before the determination of a deficient practice is considered. Whether it's a grievance that crops up during survey, or one that has been previously identified, facilities have ample time to produce the appropriate documentation to show that they've acted in good faith in responding to the issue.

**5. Keep the facility's resident** nudist out of sight during the tour. Residents have rights, and many of them exhibit what might be considered to be peculiar behavior. Long term care providers often become squeamish about these things during survey for fear that somewhere there's an F-tag looming that prohibits a Bohemian lifestyle. For example, one facility in the Northeast is home to a man who enjoys walking around in his room naked all day. He keeps the door closed and the room suitably warm. He wears protective footwear. He does not have a roommate. He dresses when he leaves the room, but chooses not to attend activities. Nevertheless, staff expressed concern that the state would find his eccentric behavior grist for the deficiency mill. In reality, however, the facility actually acted in compliance with the regulations by protecting the patient's right of free choice. No harm has occurred to date, nor is there evidence to support that potential harm is imminent.

**6. When it comes to care planning**, more is better. Care plans should succinctly tell the reader what the problem is, what interventions are in place, what's working, and what hasn't. They should not be repositories of medical histories, accident incident investigations, or chronologies of psychotropic drug trials. Unfortunately, many care plans are overloaded with information, presumably in order to create an impression that says, "look at everything we're doing! We haven't missed anything." This approach to care planning often obscures the main objective of the document.

Another popular myth is that surveyors scowl at preprinted care plans. It is important to remember that it is the content in the care plans that matters. Whether or not they're computerized or written is a matter of preference.

**7. It's risky to bother the team** leader if you have a concern or issue. Team leaders are generally quite receptive to meeting with directors of nursing or administrators if there are issues or concerns that need to be discussed. Such issues should be presented in a professional context with supportive data. Facility staff should be respectful, yet assertive if necessary, and never play the role of victim.

**8. Sometimes, there's nothing** staff can do to help these patients. If there are patients who chronically fall or act violently, for example, a facility must try harder to come up with a solution. Surveyors will not accept the excuse that "nothing can be done." When traditional interventions fail, answers may be found on the Internet or by conferring with a colleague. If all else fails, the facility should hire a consultant. The proverbial rule of regulatory logic says that "if at first you don't succeed, try, try again."

**9. A psychiatric consult in the** chart will satisfy a facility's behavioral management requirements. Patient behavior needs immediate attention. Though psychiatric treatment is an integral part of behavior management, even stat changes in medication take time to work, and longer to evaluate. Behavioral disturbances require practical approaches that are designed to ensure safety and well-being. To the survey team, the fact that a facility obtains a psychiatric consult—which may take hours, or even days—generally will not suffice as the primary intervention for patients with difficult-to-manage behaviors.

**10. There's no way to predict** what surveyors are going to find wrong. Though even the keenest eyes in a facility may overlook some things, there are ways to anticipate what issues the team will be interested in. First, a facility should look at its quality indicators and determine which patients trigger for sentinel events or other significant concerns. Resident council minutes should be thoroughly reviewed. The facility should also determine which residents, medical records, or issues create the most apprehension. Any lingering concerns should be attended to appropriately. A good rule of thumb is to review one F-tag each week during interdisciplinary meetings to familiarize staff with the regulations. Staff should pretend they're having company for dinner. How does the facility look? Sound? Smell? Finally, environmental items that can be easily corrected must never be overlooked.

Long term care providers need to avoid becoming distracted by the popular mythology surrounding surveys and surveyors. The anxieties experienced during the survey process are understandable, yet are best mitigated with thoughtful care planning, the pursuit of state-of-the-art interventions, and a comprehensive understanding of the regulations. ■

### For More Information

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# New Dementia Care Guidelines Issued

Improved care surrounding nutrition and hydration, pain management, and social involvement can make a significant difference in the quality of life of a patient or resident with dementia, according to guidelines released by the Alzheimer's Association.

"Dementia Care Practice Recommendations for Assisted Living Residences and Nursing Homes" is based on a three-year study conducted by University of North Carolina at Chapel Hill researchers and funded by the Alzheimer's Association, along with a comprehensive literature review.

The guidelines received the support of 24 leading organizations representing a range of long term care providers, care staff professionals, and consumers, including the American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL). "We need to assure quality care for all patients and residents, and this is a perfect framework for addressing problems that face many citizens receiving long term care—understanding the communication barriers with dementia patients and how best to meet their needs," says Hal Daub, president and chief executive officer of AHCA/NCAL.

The guidelines center around fundamentals of dementia care and three priority areas: food and fluid consumption, pain management, and social engagement.

## Dementia Care Fundamentals

Recommendations for the fundamentals emphasize person-centered, holistic assessments, well-informed staff, and a homelike environment.

A holistic assessment of the residents' abilities and backgrounds should include cognitive health, physical health, physical functioning, behavioral status, sensory capabilities, decision-making capacity, communication abilities, personal background, cultural preferences, and spiritual needs and preferences.

Person-centered care planning includes the resident and his or her family, along with all of the resident's routine caregivers, in the care-planning process itself. The plan should build on the resident's abilities and use such strategies as task breakdown, fitness programs, and physical or occupational therapy to maintain the resident's functional abilities as long as possible.

Staff training topics should include:

- Dementia, including the progression of the disease, memory loss, and psychiatric and behavioral symptoms;
- Strategies for providing person-centered care;
- Communication issues;
- A variety of techniques for understanding and approaching behavioral symptoms, including alternatives to restraints;
- An understanding of family dynamics; and
- Information on how to address specific aspects of care such as pain management.

## Food And Fluid Consumption

Nutrition screening and a thorough assessment are the foundations for providing optimal nutrition care, according to the guidelines. Residents should be assessed for things that could interfere with consumption, such as poor dental health; swallowing difficulties; distractibility during meals; and impairments in balance, coordination, strength, or endurance. Assessments should also include observing residents for such warning signs as:

- Difficulty chewing and swallowing or changes in swallowing ability;
- Poor utensil use;
- Refusing substitutions;
- Low attentiveness to a meal or wandering away during a meal; and
- More than 25 percent of food uneaten during a meal.

Staff can use a variety of approaches to stimulate consumption, such as allowing mealtimes to be rescheduled for a different time of day if a resident exhibits time- or light-dependent agitation, distraction, or disorientation. Also, staff should sit and make eye contact and speak with residents when assisting with meals.

## Pain Management

Pain assessment should be frequent and address the site of the pain, type of pain, effect of pain on the resident or patient, pain triggers, whether pain is acute or chronic, and positive and negative consequences of treatment.

All staff, including direct care staff, should have a role in pain assessment by being trained to record their observations and report signs of pain to licensed nursing staff.

## Social Engagement

Social interactions give residents the opportunity to maintain and enhance their sense of dignity and self-esteem, but staff need training to understand how to help them achieve this goal, according to the guidelines. An initial assessment should include:

- Capacity for physical movement;
- Capacity for mental stimulation;
- Interest in social interaction;
- Desire for spiritual participation and fulfillment;
- Cultural values and appreciation; and
- Various specific recreational interests and preferences.

Activity planning should take into account that some residents experience increased confusion, agitation, and movement at the end of the day. The guidelines also recommend that group dynamics and the overall mood of the group should be monitored, and all staff should be flexible in adapting the focus of the activity.

—Kathleen Vickery