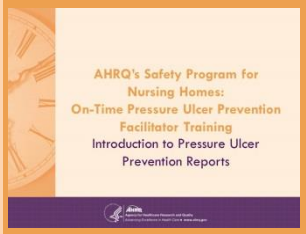
AHRQ's Safety Program for Nursing Homes: On-Time Pressure Ulcer Prevention

Facilitator Training Instructor Guide

Slide 1: Introduction to Pressure Ulcer Prevention Reports



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SAY:

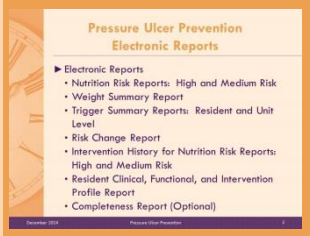
In this session we will introduce you to the pressure ulcer prevention electronic reports.

Slide 2: Pressure Ulcer Prevention Electronic Reports

SAY:

This section will cover each component of Pressure Ulcer Prevention, which includes the following electronic reports. The electronic reports are:

- Nutrition Risk Reports: High Risk and Medium Risk
- Weight Summary Report
- Trigger Summary Reports: Resident Level and Unit Level
- Risk Change Report
- Intervention History for Nutrition Reports: High Risk and Medium Risk
- Resident Clinical, Functional, and Intervention Profile Report
- Completeness Report, an optional report.



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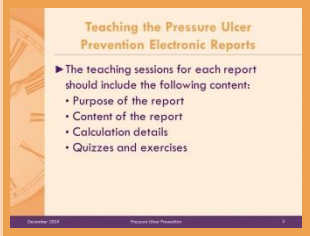
Slide 3: Teaching the Pressure Ulcer Prevention Electronic Reports



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SAY:

This training will provide you with the information you need to teach the reports to the nursing home change team. The training will follow a similar approach to how you should present the reports to the nursing home team. We will:

- **Step 1:** Review the purpose of the report.
- **Step 2**: Describe the content of the report.
- **Step 3**: Discuss the calculation details:

The facilitator needs to understand the sources of the data in each report, criteria for inclusion of residents in each report, and the calculations that create the elements in the report: the column headings and cell content. With this knowledge, the facilitator can answer questions that may arise about the content and accuracy of the reports. Nursing home staff need to master enough details about the report to be able to see the value of the reports, judge the accuracy of the reports, and use them to help make care plan decisions.

- **Step 4**: Use quizzes and exercises that are provided for each report to test participants' understanding.

DO:

- Use additional quiz questions and exercises provided as a handout to further test understanding of calculation details, if needed.

Slide 4: Nutrition Risk Reports title slide

SAY:

Now let's begin going over each of the reports.

Slide

Slide 5: Nutrition Reports: High Risk and Medium Risk

SAY:

Slide

The Nutrition Risk Reports (High Risk and Medium Risk) provide the clinician with an overall picture of resident nutrition risk status. These reports are intended to provide an early warning about residents with subtle changes or decline in nutritional status so that actions may be taken before significant weight loss occurs and nutrition problems develop that can affect skin integrity. The user can see residents with subtle declines in meal intake and additional details about the resident at a glance.

The report can help answer the following questions:

- What is the resident's diet? How long has the resident been on this diet?
- Does the diet need to be changed?
- Is the resident on tube feeding? If no, then an order can be considered.
- Is the resident on supplements? If yes, the average supplement intake will display. If the supplement intake is insufficient, then care plan interventions can be considered. If there is no order for supplements, then an order to start supplements can be considered.
- Is the resident also experiencing weight loss? This report can be paired with the Weight Summary Report to see additional detail about resident weight values and trends.

The Nutrition Risk Report goes beyond using a single data point as a trigger for risk, such as 25 percent meal intake for lunch, and presents a broader picture of risk, meal intake trends, and current interventions. It does not include all interventions, but enough to initiate care plan discussions among disciplines. The report enhances decision making and prompts clinicians to conduct further assessment and chart review and to consider changing current interventions or generating referrals or notifications to the physician.

The Nutrition Risk Reports (High Risk and Medium Risk) display weekly resident-level information for a single nursing unit. They show:

- The first date that decreased meal intake was observed;
- Average weekly meal intake for 4 consecutive weeks;
- Diet order;
- Tube feeding status;
- Average supplement intake for the report week;
- Any recent weight change;
- Most recent ulcer assessment date; and
- Number of pressure ulcers.

Slide

Slide 6: Nutrition Reports: High Risk and Medium Risk Criteria

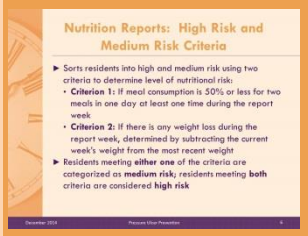
SAY:

The report sorts residents into high and medium nutritional risk using two criteria to determine level of risk:

- Criterion #1: If meal consumption is 50 percent or less for two meals in *one day at least one time during the report week*.
- Criterion #2: If there is *any* weight loss during the report week, determined by subtracting the current week's weight from the most recent weight.

Residents meeting **either one of the criteria** will display as ***medium risk***; residents meeting **both criteria** will display as ***high risk***.

- In addition, if the resident is tube fed and has weight loss during the report week, the resident will display on the Nutrition Report: High Risk; and
- If a resident is tube fed (no weight loss) during the report week, the resident will *always* display on the Nutrition Report: Medium Risk.



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Slide 7: Sample Nutrition Report: High Risk

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DO:

Instruct trainees to look at Nutrition Risk Report handout. Review the report contents and point out special features.

Sample Nutrition Report
High Risk: Decreased meal intake and weight loss during report week
Unit A

Resident	Room Number	Decreased Intake: First Date	Avg Meal Intake % 3/1/14	Avg Meal Intake % 3/8/14	Avg Meal Intake % 3/15/14	Avg Meal Intake % 3/22/14	Diet	TF	Avg Supplement Intake %	Weight Change in lb	Most Recent Ulcer Assess Date	# Pr Ulcers
A	001	03/22/2014	50	41	36	29	Pureed 2/28/14	X		-1.5	3/20/14	2
B	002	03/16/2014	64	52	47	45	Mech 1/22/14		50%	-3.3	3/20/14	1
C	003	03/19/2014	74	62	58	42	Reg 3/22/14			-1.5		
D	004	03/17/2014	86	89	71	59	Reg 12/3/13			-2.5		

Slide 8: Reviewing Nutrition Report Calculation Details

DO:

Review the calculation details with facilitator trainees.

SAY:

The On-Time software performs various calculations to display the relevant information. We will review how the different fields are determined.

Decreased Intake: First Date is the date of the report week the resident first had a meal intake of 50 percent or less for two meals in one day.

- This is the first date during the week that a resident has less than 50 percent for two meals in one day regardless of the average weekly intake.
- This may occur more than once during the report week, but the first date of occurrence will display.
- This is based on meal documentation for the current week to help focus the team on recent changes and information.

***Average Weekly Meal Intake*.** This is the average percentage of meals consumed for one full week, including breakfast, lunch, and dinner. It takes into account missed meals, refusals, and NPO status.

- The numerator is the sum of meal intake percentages (includes breakfast, lunch, and dinner) for all meals for each week of the 4 weeks prior to report ending date. The denominator is the total possible meals in one week. If a resident is available for each meal then the denominator is 21; NPO does not affect the denominator. Total possible meals may vary for new admissions or readmissions.
- NPO and missed meals affect the average meal intake value (count as 0 percent intake).

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- Missing documentation or unavailable for meal (out of the building) are not included in the denominator.
- If the report is run for the current week, the denominator adjusts to the day of the week that the report is generated. For example, a report generated on Thursday would have a total of nine possible meals (Monday, Tuesday, and Wednesday).

Diet Order and Date. This is the resident's current diet and the date that it was ordered by the physician. If the resident has an order for NPO, NPO will be displayed with the date it was ordered.

Tube Feeding. If the resident is receiving tube feeding during the current report week, then an X will display.

- Tube feeding information can be generated from active orders or nurse/nursing assistant documentation, depending on the EMR vendor's software capabilities.
- Residents receiving meals only through tube feeding will have a meal percentage intake of zero. These residents trigger for high risk if there is weight loss during the report week and medium risk if there is no weight loss during the report week.

Average Supplement Intake Percentage. If the resident has a physician order for supplements, the average supplement intake percentage is calculated as the average percentage of supplement intake for the report week.

- The numerator is the sum of all percent intakes of supplements for the report week.
- The denominator is supplement order frequency. If order frequency is once daily, then the denominator is 7; twice daily, the denominator is 14; etc.
- If the supplement is ordered PRN, no average supplement intake is calculated and the cell is left blank.

***Weight Change in Pounds*.** Not all nursing homes weigh residents weekly. If there is any weight loss during the report week, the weight loss value will display as a negative number.

- Change in weight in pounds is the change from the previous (most recent) weight to the current weight (Current Weight minus Previous Weight).
  Current weight is from the report week.
- Previous weight is the next most recent lowest weekly weight within the last 200 days.

Slide

- If multiple weights are taken in one week, the lowest weight is used as the weekly weight.
- Weight change will not display if no weight was recorded during the report week.
- If no current weekly weight is available, the resident will not display on the High-Risk Nutrition Report.

Most Recent Ulcer Assessment Date. If nurses are not documenting pressure ulcer assessments in the EMR, then leave the cell BLANK. (The EMR vendor has the option to remove the column from the report display.)

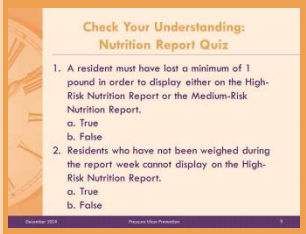
- If nurses are documenting pressure ulcer assessments in the EMR, then display the date of the most recent pressure ulcer assessment.
- If there are two assessments in the prior week, then use the assessment having a date closest and prior to the report date.

Number of Pressure Ulcers. Count the number of unique ulcers for the resident and display the count. Do not count ulcers that are considered inactive or healed.

Slides 9–11: Check Your Understanding: Nutrition Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



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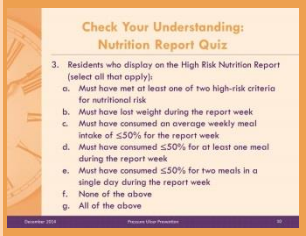


Slide 9

1. A resident must have lost a minimum of 1 pound in order to display either on the High-Risk Nutrition Report or the Medium-Risk Nutrition Report.

   a. True
   b. False

   ANSWER: b

2. Residents who have not been weighed during the report week cannot display on the High-Risk Nutrition Report.

   a. True
   b. False

   ANSWER: a

Slide 10

3. Residents who display on the High-Risk Nutrition Report (select all that apply):

   a. Must have met at least one of two high-risk criteria for nutritional risk
   b. Must have lost weight during the report week
   c. Must have consumed an average weekly meal intake of ≤50 percent for the report week
   d. Must have consumed ≤50 percent for at least one meal during the report week
   e. Must have consumed ≤50 percent for two meals in a single day during the report week
   f. None of the above
   g. All of the above

   ANSWER: b and e

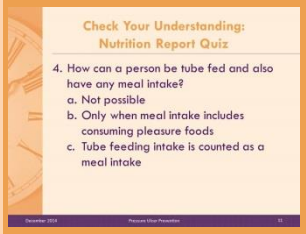
Slide 11

4. How can a person be tube fed and also have any meal intake?

    a. Not possible
    b. Only when meal intake includes consuming pleasure foods
    c. Tube feeding intake is counted as a meal intake

    ANSWER: b

Note: Use additional questions and exercises located in the handout with facilitator trainees, if needed.



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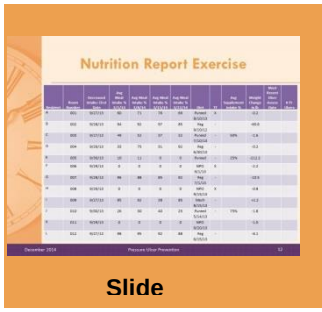
Slide 12: Nutrition Report Exercise



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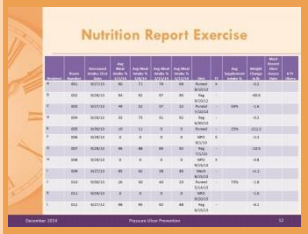
DO:

Have participants review the sample report shown. Ask them to look for any information that may be inaccurate. Then lead the team in a discussion of their findings.

Resident	Room Number	Decreased Intake: First Date	Avg Meal Intake % 3/1/14	Avg Meal Intake % 3/8/14	Avg Meal Intake % 3/15/14	Avg Meal Intake % 3/22/14	Diet	TF	Avg. Supplement Intake %	Weight Change in lb	Most Recent Ulcer Assess Date	# Pr Ulcers
A	001	3/17/14	60	71	76	69	Pureed 8/10/13	X		-0.2		
B	002	3/18/14	94	92	97	85	Reg 9/10/12	-		-60.6		
C	003	3/17/14	49	52	37	32	Pureed 7/10/13	-	50%	-1.6		
D	004	3/19/14	33	75	31	92	Reg 6/30/13	-		-0.2		
E	005	3/20/14	10	11	0	0	Pureed	-	25%	-212.2		
F	006	3/19/14	0	0	0	0	NPO 9/1/13	X		-2.2		
G	007	3/18/14	96	88	85	92	Reg 7/1/13	-		-10.5		
H	008	3/19/14	0	0	0	0	NPO 9/15/13	X		-0.8		
I	009	3/17/14	85	92	38	85	Mech 8/15/13	-		+1.2		
J	010	3/20/14	26	30	40	25	Pureed 5/14/13	-	75%	-1.8		
K	011	3/19/14	0	0	0	0	NPO 9/20/13			-1.0		
L	012	3/17/14	98	95	92	88	Reg 6/15/13	-		-6.1		



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ANSWERS:

- Resident 001. Verify that this person is eating 60 to 76 percent and is on tube feeding.
- Resident 002. Very large weight loss (60 pounds)—Is this accurate?
- Resident 003. Is it really possible that the resident was eating between 32 and 52 percent and lost only 1.6 pounds?
- Resident 005. Another very large weight loss (212.2 pounds) - Is this accurate?
- Resident 007. Eating 85 to 96 percent and still losing weight - Is this accurate?
- Resident 010. Eating 25 to 40 percent and lost only 1.8 pounds - Is this accurate?
- Resident 011. No intake and no tube feed and only 1 pound weight loss - Is this accurate?
- Resident 012. Eating 88 percent or more with a 6.1 pound weight loss - Is this accurate?

ASK:

How would you investigate these potential inaccuracies?

Slide 13: Weight Summary Report title slide

SAY:

We'll now move to the next report, the Weight Summary Report.

Slide

Slide 14: Weight Summary Report

SAY:

Slide

The Weight Summary Report provides trended views of resident weight values for up to 180 days. Its purpose is to help the team focus on specific residents at potential nutrition risk as a result of weight loss and therefore at risk for pressure ulcer development.

This report:

- Displays 4 weeks of trended weights for each resident
- Calculates weight changes
- Displays alternative significant weight loss measures:
- ≥2 percent From Previous Week
- ≥5 percent in Prior 30 days
- ≥7.5 percent in Prior 90 days
- ≥10 percent in Prior 180 days

Weights are calculated in two ways:

- ***Point-to-Point*** is calculated using two data points, to determine if weight loss occurred.
- ***Any Weight Loss*** is calculated using multiple weight comparisons within a specified period to identify "any" weight loss within the period. In the calculations of any weight loss, multiple significant weight changes may occur.

Slide 15: Sample Weight Summary Report

Slide

DO:

Instruct trainees to look at Weight Summary Report handout. Review the report contents and point out special features.

Name	ID	Weight 180 Days Prior	Weight 90 Days Prior	Weight 30 Days Prior	Weight for Week 5/3/14 Week4	Weight for Week 5/10/14 Week3	Weight for Week 5/17/14 Week2	Weight for Week 5/24/14 Week1	Weight Change lb	≥2% Wt Loss (from previous week)	≥5 lb Wt Loss in Prior 30 Days	≥5% Wt Loss in Prior 30 Days	≥5% Wt Loss in Prior 30 Days (Any)	≥7.5% Wt Loss in Prior 90 Days	≥10% Wt Loss in Prior 180 Days
A	###1	285.3	275.0	254.5	252.4	256.1	251.7	253.8	2.1, 5/24/14					7.7%	11.0%
B	###2	172.1	175.3	180.0	180.0	170.0	181.0	171.0	-10.0, 5/24/14	5.5%	9.0	5.6%	5.6%, 5/10/14; 5.0%, 5/24/14 5.5%, 5/24/14		

Slide 16: Reviewing Calculation Details for Weight Summary Report

DO:

Review the weight item definitions and calculation details with facilitator trainees.

SAY:

Let's review how the different fields on the Weight Summary Report are determined.

Weight in Prior 180 Days displays the weight of the resident approximately 180 days prior to the most recent resident weight.

Weight in Prior 90 Days displays the weight of the resident approximately 90 days prior to the most recent resident weight.

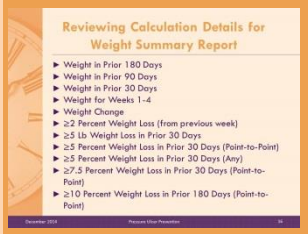
Weight in Prior 30 Days displays the weight of the resident approximately 30 days prior to the most recent resident weight.

Weight calculations performed by the software follow:

- 180 days: Identifies all weights taken between 170 and 190 days and selects the one closest to the 180-day target.
- 90 days: Identifies all weights taken between 85 and 95 days and selects the one closest to the 90-day target.
- 30 days: Identifies all weights taken between 25 and 35 days and selects the one closest to the 30-day target.
- For any of the above, if two weights are the same distance from the target date, the lowest weight is used.

Weight for Weeks 1 to 4. Displays trended view of lowest weight for each week in a 4-week period. Week Ending Date is displayed in each of the four column headers.

- If multiple weights are taken in one week, the lowest weight is used as the weekly weight.



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- If a resident is weighed monthly, some of the weekly weights will be blank.

Weight Change in Pounds is the change in weight from the previous weight to the most recent weight (Most Recent Weight minus Previous Weight).

- Current Weight is weight from report week.
- Previous Weight is the next most recent lowest weekly weight within the last 200 days.
- Weight Change in pounds will not display if no weight is recorded during the report week.

≥2 Percent Weight Loss (from previous week) displays the percentage weight loss of a resident if weight loss is ≥2 percent compared to the previous week; otherwise, cell is left empty.

- Take Weight 7 Days Prior value, and subtract from most recent weight (Most recent minus 7 days prior).
- If value is positive, disregard; if negative, take absolute value and divide by Weight 7 Days Prior value. Multiply by 100. Round to one decimal place. Display value if ≥2 percent. Indicate with percent sign.
- Item will not display if no weight is recorded during the report week.

≥5 Lb Weight Loss in Prior 30 Days displays number of pounds of weight loss if weight loss is ≥5 pounds within the last 30 days; otherwise, cell is left empty.

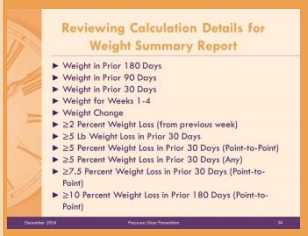
- Item will not display if no weight is recorded during the report week.

Calculation steps follow:

- Take weight change in pounds from Weight Prior 30 Days to most recent weight (Most recent minus 30 days prior).
- If weight change is positive, disregard; if negative, take absolute value.
- If weight loss ≥5 pounds, display the weight loss value in pounds.

≥5 Percent Weight Loss in Prior 30 Days (Point-to-Point) displays the percent weight loss of ≥5 percent compared to weight closest to 30 days prior.

- Item will not display if no weight is recorded during the report week



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Calculation steps follow:

- Take the value calculated above in ≥5 lb Weight Loss in Prior 30 Days, and divide by Weight 30 Days Prior. Multiply by 100. Round to one decimal place.
- Display the value if ≥5 percent. Display value as percentage.

≥5 Percent Weight Loss in Prior 30 Days (Any). Displays percent weight loss for all occurrences of a resident weight loss of ≥5 percent in the last 30 days.

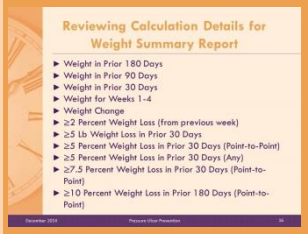
- Item will not display if no weight is recorded during the report week.

Calculation steps follow:

- Take weights/dates identified in Weight for Week columns (one weight/date per week, with up to four per resident).
- Week one is most recent week; week two is second most recent; etc.
- Iteration one: Take week four weight and subtract from week three through week one weights (week three minus week four, week two minus week four, week one minus week four); if value is positive, disregard; if negative, take absolute value and divide by week four weight. Multiply by 100 and round to one decimal place.
- Iteration two: Take week three weight and subtract from week two and week one weights (week two minus week three, week one minus week three); if value is positive, disregard; if negative, take absolute value and divide by week three weight. Multiply by 100 and round to one decimal place.
- Iteration three: Take week two weight and subtract from week one weight (week one minus week two); if value is positive, disregard; if negative, take absolute value and divide by week two weight. Multiply by 100 and round to one decimal place.

Here is an example:

1. Four weights are taken for a resident: 180.0 on 5/3/14; 170.0 on 5/10/14; 181.0 on 5/17/14; and 171.0 on 5/24/14 (where 5/18 to 5/24 is the most recent week).
2. First iteration yields -10.0, 1.0, and -9.0; take absolute value of -10.0 and -9.0, and divide each by 180.0, yielding .056 times 100 equals 5.6 percent and.050 times 100 equals 5.0 percent.



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3. Second iteration yields 11.0, 1.0; disregard both values.
4. Third iteration yields -10.0; take absolute value, and divide by 181.0, yielding .055 times 100 equals 5.5 percent.

- Column output: 5.6%, 5/10/14; 5.0%, 5/24/14; 5.5%, 5/24/14 (displayed on Sample Report on Slide 20).

≥7.5 Percent Weight Loss in Prior 90 Days (Point-to-Point) displays percent weight loss if the resident weight loss is ≥7.5 percent within the last 90 days; otherwise, cell is left empty.

- Item will not display if no weight is recorded during the report week.

Calculation steps follow:

- Take Weight 90 Days Prior value, and subtract from most recent weight (most recent minus 90 days prior).
- If value is positive, disregard; if negative, take absolute value and divide by Weight 90 Days Prior value. Multiply by 100. Round to one decimal place. Display value if ≥7.5 percent. Indicate with percent sign.

≥10 Percent Weight Loss in Prior 180 Days (Point-to-Point). Displays percent weight loss if the resident weight loss is ≥10 percent within the last 180 days.

- Item will not display if no weight is recorded during the report week.

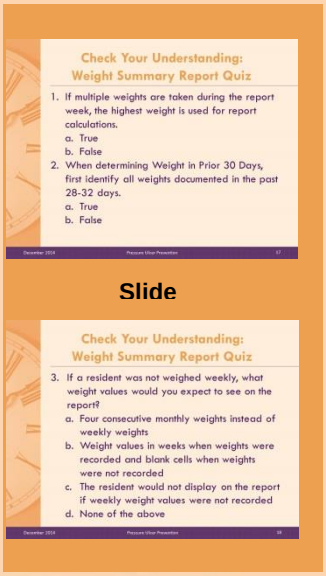
Calculation steps follow:

- Take Weight 180 Days Prior value, and subtract from most recent weight (most recent minus 180 days prior).
- If value is positive, disregard; if negative, take absolute value and divide by Weight 180 Days Prior value. Multiply by 100. Round to one decimal place.
- Display value if ≥10 percent. Indicate with percent sign.

Slides 17–19: Check Your Understanding: Weight Summary Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



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Slide 17

1. If multiple weights are taken during the report week, the highest weight is used for report calculations.

   a. True
   b. False

   ANSWER: b (uses lowest weight)

2. When determining ***Weight in Prior 30 Days***, first identify all weights documented in the past 28 to 32 days.

   a. True
   b. False

   ANSWER: b (range used is 25 to 35 days)

Slide 18

3. If a resident was not weighed weekly, what weight values would you expect to see on the report?

   a. Four consecutive monthly weights instead of weekly weights
   b. Weight values in weeks when weights were recorded and blank cells when weights were not recorded
   c. The resident would not display on the report if weekly weight values were not recorded
   d. None of the above

   ANSWER: b

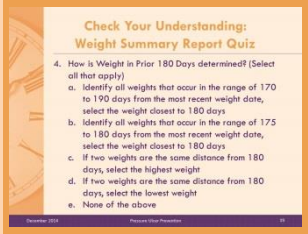
Slide 19

4. How is **Weight in Prior 180 Days** determined? (Select all that apply)

    a. Identify all weights that occur in the range of 170 to 190 days from the most recent weight date, select the weight closest to 180 days
    b. Identify all weights that occur in the range of 175 to 180 days from the most recent weight date, select the weight closest to 180 days
    c. If two weights are the same distance from 180 days, select the highest weight
    d. If two weights are the same distance from 180 days, select the lowest weight
    e. None of the above

ANSWERS: a and d

Note: Use additional questions and exercises located in the handout with facilitator trainees, if needed.



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Slide 20: Trigger Summary Reports title slide

SAY:

Let's now move to the next report, the Trigger Summary Report.

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Slide 21: Trigger Summary Reports: Resident Level and Unit Level

SAY:

Slide

The Trigger Summary Report identifies residents at risk for pressure ulcer development due to an increase in their pressure ulcer risk factors from the prior week. Available at the resident and unit level, it reports on nine risk factors or "triggers" associated with pressure ulcer development. For example, a resident with two triggers the prior week and five in the current week would suggest a dramatic increase in risk to develop a pressure ulcer, prompting questions such as:

- What can explain this change?
- Is the entire care team aware of this increasing risk?
- Has the care plan been updated to reflect this change?
- Do care plan interventions address risk identified on the report or the changes that the clinicians may discover during a followup assessment?

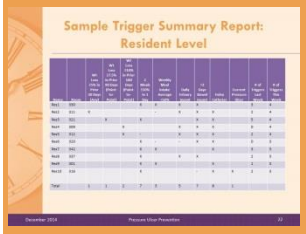
These risk factors or triggers are derived primarily from electronic nursing assistant documentation and include the following:

- Weight loss ≥5 percent in the prior 30 days.
- Weight loss ≥7.5 percent in the prior 90 days.
- Weight loss ≥10 percent in the prior 180 days.
- Two meals with intake ≤50 percent in one day.
- Weekly meal intake averaging <50 percent.
- Daily urinary incontinence.
- More than 3 days of bowel incontinence.
- Presence of a Foley catheter.
- Current pressure ulcer.

The report displays residents who have at least one trigger activated during the report week presented in descending order of total number of pressure ulcer triggers for the report week. The report displays the prior week trigger totals and the current total, and provides a weekly snapshot of a resident's risk for pressure ulcer development.

The report does not include recommended followup but does display enough information to prompt the clinician to conduct a followup assessment, collaborate with multiple disciplines, confirm that existing care plan interventions are appropriate, and communicate the changes in risk to the entire care team.

Slide 22: Sample Trigger Summary Report: Resident Level



Slide

DO:

Instruct trainees to look at Trigger Summary Report: Resident Level handout. Review the report contents and point out special features.

Name	Room	Wt Loss ≥5% in Prior 30 Days (Any)	Wt Loss ≥7.5% in Prior 90 Days (Point-to-Point)	Wt Loss ≥10% in Prior 180 Days (Point-to-Point)	2 Meals ≤50% in 1 Day	Weekly Meal Intake Average <50%	Daily Urinary Incont	>3 Days Bowel Incont	Foley Catheter	Current Pressure Ulcer	# of Triggers Last Week	# of Triggers This Week
Res1	330				X	X	X	X			3	4
Res2	311	X			X	-		X	X		2	4
Res3	321	X	X		X	X		X			5	5
Res4	309			X		X	X	X			0	4
Res5	312			X	-	X	X	X			2	4
Res6	320		X		X	-	-	X			0	3
Res7	342	X			X	X					3	3
Res8	337				X		X	X			2	3
Res9	301				X	X	X				1	3
Res10	316				X		X	-		X	2	3
Total		3	2	2	8	6	6	7	1	1		

Slides 23: Reviewing Calculation Details for the Trigger Summary Report: Resident Level

Slide

DO:

Review the calculation details with facilitator trainees.

SAY:

Let's review how the various fields are determined.

***Weight Loss ≥5 Percent in Prior 30 days* (Any).** Displays an X if the resident has any occurrence of weight loss ≥5% in the last 30 days. Uses same calculations as used in Weight Summary Report.

- Item will not display if no weight is recorded during the report week.

Weight Loss ≥7.5 Percent in Prior 180 days. Displays an X if the resident has a weight loss of ≥7.5% in the last 90 days. Uses the same calculations as used in the Weight Summary Report**.**

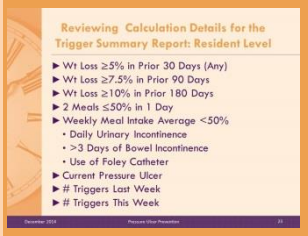
- Item will not display if no weight is recorded during the report week.

Weight Loss ≥10 Percent in Prior 180 days. Displays an X if the resident has a weight loss of ≥10% in the last 180 days. Uses the same calculations as used in the Weight Summary Report**.**

- Item will not display if no weight is recorded during the report week.

***2 Meals ≤50 Percent in 1 Day*.** Displays an X if the resident consumes 50 percent or less of each of two meals in a single day during the report week.

- Measure is also on the Nutrition Report.



Slide

Weekly Meal Intake Average <50 Percent. Displays an X if the resident's average intake of breakfast, lunch, and dinner is less than 50% for the report week. Uses the same calculations as for the Nutrition Report.

- If meal completeness documentation is <75 percent for the current week, the cell will show a dash.

***Daily Urinary Incontinence*.** Displays an X if the resident has urinary incontinence everyday for the current report week.

- Urinary incontinence is daily if urinary incontinence is documented for at least one shift for each day during the report week.

***>3 Days of Bowel Incontinence*.** Displays an X if the resident has documented bowel incontinence at least once per day for at least 4 days during the report week.

- >3 days of bowel incontinence: at least one episode of bowel incontinence on 4 or more days during the report week.

***Use of Foley Catheter*.** Displays an X if the resident has documented Foley catheter use.

- Presence of Foley catheter may be identified from multiple sources (nursing assistant documentation, nurse documentation, physician orders).

***Current Pressure Ulcer*.** Displays an X if the resident has at least one pressure ulcer for the current week. Does not indicate how many pressure ulcers.

- If vendor does not offer wound assessment tool for documentation, then this column will have blank cells OR the column will not display at all.

 # Triggers Last Week: For each resident display the previous week's trigger count.

 # Triggers This Week: For each resident count the number of X's and display count.

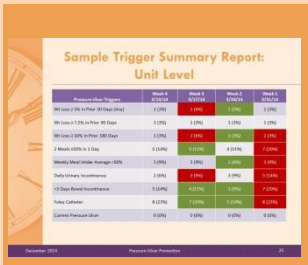
Slide 24: Trigger Summary Report: Unit Level

SAY:

The unit-level report view displays the number of residents (and percentage of total nursing unit census) who meet each trigger. Four weeks are displayed. The report is used to monitor the overall prevalence and trends of pressure ulcer triggers on a specific nursing unit. This information may be useful for program monitoring and planning or identifying staff in-service needs.

Slide

Slide 25: Sample Trigger Summary Report: Unit Level



Slide

DO:

Instruct trainees to look at Trigger Summary Report: Unit Level handout. Review the report contents and point out special features.

Pressure Ulcer Triggers	Week 4 5/10/14	Week 3 5/17/14	Week 2 5/24/14	Week 1 5/31/14
Wt Loss ≥ 5% in prior 30 Days (ANY)	1 (3%)	2 (6%)	1 (3%)	1 (3%)
Wt Loss ≥ 7.5% in prior 90 Days	1 (3%)	1 (3%)	1 (3%)	1 (3%)
Wt Loss ≥ 10% in prior 180 Days	1 (3%)	2 (6%)	1 (3%)	2 (3%)
2 Meals ≤50% in 1 Day	5 (14%)	4 (11%)	4 (11%)	7 (20%)
Weekly Meal Intake Average <50%	3 (9%)	3 (9%)	2 (6%)	3 (9%)
Daily Urine Incontinence	2 (6%)	3 (9%)	3 (9%)	5 (14%)
>3 Days Bowel Incontinence	5 (14%)	4 (11%)	3 (9%)	7 (20%)
Foley Catheter	8 (23%)	7 (20%)	5 (14%)	8 (23%)
Current Pressure Ulcer	0 (0%)	0 (0%)	0 (0%)	0 (0%)

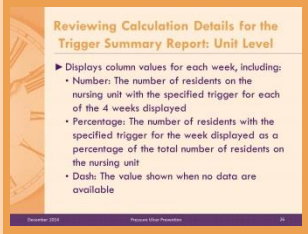
SAY:

In the following example, the report has been color coded with red representing an increase, green, a decrease, and white, no change in weekly pressure ulcer trigger prevalence. Vendors may use different indicators to highlight changes in prevalence of pressure ulcer triggers.

Slide 26: Reviewing Calculation Details for the Trigger Summary Report: Unit Level

DO:

Review the calculation details with facilitator trainees. Calculation details are the same as for the Resident-Level report.

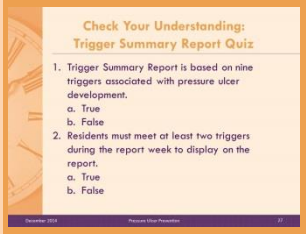


Slide

Slides 27–29: Check Your Understanding: Trigger Summary Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



Slide

Slide 27

1. Trigger Summary Report is based on nine triggers associated with pressure ulcer development.

   a. True
   b. False

   ANSWER: a

2. Residents must meet at least two triggers during the report week to display on the report.

   a. True
   b. False

   ANSWER: b

Slide 28

3. There are three views of the Trigger Summary Report – Resident Level, Unit Level, and by Specific Trigger.

   a. True
   b. False

   ANSWER: b

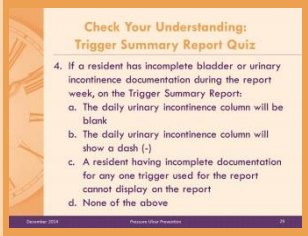
Slide 29

4. If a resident has incomplete bladder or urinary incontinence documentation during the report week, on the Trigger Summary Report:

   a. The daily urinary incontinence column will be blank
   b. The daily urinary incontinence column will show a dash (-)
   c. A resident having incomplete documentation for any one trigger used for the report cannot display on the report
   d. None of the above

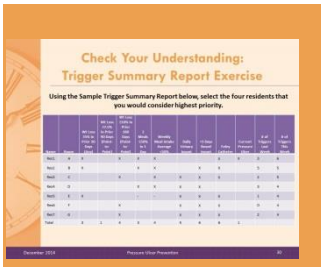
   ANSWER: b

Note: Use additional questions and exercises located in the handout with facilitator trainees, if needed.



Slide

Slide 30: Check Your Understanding: Trigger Summary Report Exercise



Slide

DO:

Ask participants to use the sample Trigger Summary Report below to select four residents they would consider highest priority.

Name	Room	Wt Loss ≥5% in Prior 30 Days (Any)	Wt Loss ≥7.5% in Prior 90 Days (Point-to-Point)	Wt Loss ≥10% in Prior 180 Days (Point-to-Point)	2 Meals ≤50% in 1 Day	Weekly Meal Intake Average <50%	Daily Urinary Incont	>3 Days Bowel Incont	Foley Catheter	Current Pressure Ulcer	# of Triggers Last Week	# of Triggers This Week
Res1	A	X		X	X	X			X	X	3	6
Res2	B	X			X	X	X	X			5	5
Res3	C			X	X	X	X	X			2	5
Res4	D				X	X	X	X			3	4
Res5	E	X			-	-	X	X			1	3
Res6	F			X			X	X			0	3
Res7	G			X			X	X			2	3
Total		3	0	4	4	4	6	6	1	1		

Answer: Residents 1, 3, and 5 would be highest priority because of a spike in the number of triggers. Resident 6 is likely a readmission because 0 in the prior week usually indicates there were no prior counts.

Slide 31: Risk Change Report title slide

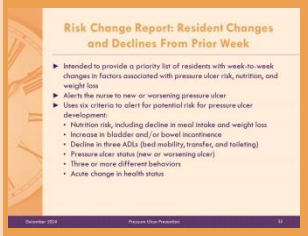
SAY:

Let us now move to the next report, the Risk Change Report.

Slide

Slide 32: Risk Change Report: Resident Changes and Declines From Prior Week

SAY:



Slide

The Risk Change Report is intended to provide a priority list of residents with week-to-week changes in factors associated with pressure ulcer risk, such as nutrition and weight loss, and alert the nurse to new or worsening pressure ulcers. The Risk Change Report prompts the clinicians to follow up on potentially subtle changes that may not have been identified using other tools, to help answer questions such as the following:

- Why did the resident flag for increase in urinary incontinence?
- Is this a subtle or dramatic change?
- Has this been addressed?
- Was it communicated on the 24-hour report?
- What resident behaviors have changed from the prior week? Are these new behaviors? Has there been followup to a potential change in behavior? What is the underlying cause?
- Is the dietitian aware that the latest wound assessment indicates a worsening in pressure ulcer status?

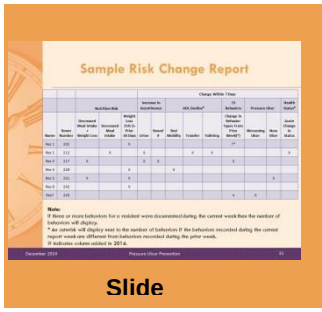
The Risk Change Report uses six criteria to alert staff to potential risks for pressure ulcer development:

- Nutrition risk, including decline in meal intake and weight loss;
- Increase in bladder and/or bowel incontinence;
- Decline in three ADLs (bed mobility, transfer, and toileting);
- Pressure ulcer status, new or worsening ulcer;
- Three or more different behaviors (an increase in behaviors or change in types of behaviors from the prior week serves as an early warning of a change in resident condition that should be further assessed to determine the underlying cause); and
- Acute change in health status.

Residents with a change in at least one of these criteria from the previous week will display on the report. All documentation is captured from electronic nurse aide documentation except "new or worsening pressure ulcer," which is captured from nurse weekly wound assessments.

The information on the report does not display recommended followup but it does prompt the clinician to take followup action.

Slide 33: Sample Risk Change Report



Slide

DO:

Instruct trainees to look at Risk Change Report handout. Review the report contents and point out special features.

					Change Within 7 Days								
		Nutrition Risk			Increase in Incontinence		ADL Decline#			≥3 Behaviors	Pressure Ulcer		Health Status#
Name	Room Number	Decreased Meal Intake + Weight Loss	Decreased Meal Intake	Weight Loss ≥5% in Prior 30 Days	Urine	Bowel#	Bed Mobility	Transfer	Toileting	Change in Behavior Types From Prior Week(*)	Worsening Ulcer	New Ulcer	Acute Change in Status
Resident 1	202			X						7*			
Resident 2	212		X		X			X	X				X
Resident 3	217	X			X	X				3			
Resident 4	229			X			X						
Resident 5	231	X		X								X	
Resident 6	242			X									
Resident 7	243									4	X		

Note:

- If three or more behaviors for a resident were documented during the current week, then the number of behaviors will display.
- An asterisk (*) will display next to the number of behaviors if the behaviors recorded during the current report week are different from behaviors recorded during the prior week.
- # indicates column added in 2014.

Slides 34: Reviewing Calculation Details for the Risk Change Report

SAY:

Slide

Let's go over how the various fields are determined.

Decreased Meal Intake AND Weight Loss. Displays an X If both criteria are true for the report week. *Decreased meal intake* is 50 percent or less for two meals in any one day. Weight loss refers to any weight loss during the report week.

Decreased Meal Intake. Displays an X when meal intake is 50 percent or less for two meals in one day but with no weight loss during the current report week.

Weight Loss ≥5 Percent in Prior 30 Days (Any). Displays an X if any occurrence of weight loss of 5 percent or more within the past 30 days.

- Item will not display if no weight is recorded during the report week.

Urinary Incontinence Increase. If the resident had an increase either in the number of shifts or number of times the resident was incontinent from the previous week. Urinary incontinence may be documented or calculated in two ways:

1. To calculate an increase in urinary incontinence by shift (yes/no):
    - For the current week, count the number of shifts a resident had at least one episode of urinary incontinence documented by the nursing assistant.
    - For the prior week, count the number of shifts a resident had at least one episode of urinary incontinence documented by the nursing assistant.
    - If the number of shifts of urinary incontinence increased by three or more (Current minus Previous ≥3), then an X is displayed.

Slide

2. To calculate an increase in urinary incontinence by the number of episodes per week:

    - For the current week, sum the number of urinary incontinence episodes documented by the nursing assistant.
    - For the prior week, sum the number of urinary incontinence episodes documented by the nursing assistant.
    - If the number of urinary incontinence episodes increased by 12 or more (Current minus Previous ≥12), then an X is displayed.

Bowel Incontinence Increase. If the resident had an increase in the number of shifts or number of episodes of bowel incontinence, an X is displayed. Bowel incontinence may be documented or calculated in two ways:

1. To calculate an increase in bowel incontinence by shift (yes/no):

    - For the current week, count the number of shifts a resident had at least one episode of bowel incontinence documented by the nursing assistant.
    - For the prior week, count the number of shifts a resident had at least one episode of bowel incontinence documented by the nursing assistant.
    - If the number of shifts of bowel incontinence increased by 1 or more (Current minus Previous ≥1), then report displays an X.

2. To calculate an increase in bowel incontinence by the number of episodes per week:

    - For the current week, sum the number of bowel incontinence episodes documented by the nursing assistant.
    - For the prior week, sum the number of bowel incontinence episodes documented by the nursing assistant.
    - If the number of bowel incontinence episodes increased by 2 or more (Current minus Previous ≥2), then report displays an X.

Slide

ADL Decline. Displays an X if there has been a decline in the resident's self-performance level from the prior week to current week for Bed Mobility, Transfer, and Toileting.

- Self-performance is rated as Independent, Supervision, Limited Assistance, Extensive Assistance, Total Dependence, or Activity Did Not Occur.
- Determine the prior weekly value for Bed Mobility by taking the highest (or most dependent) value recorded for the prior week.
- Determine the current weekly value for Bed Mobility by taking the highest (or most dependent) value recorded for the current week.
- Compare Bed Mobility prior week value to current week value. If level of self-performance has declined, than an X is displayed.
- If either current week value or prior week value is Activity Did Not Occur, calculation is not done and cell is blank.
- Example: If Bed Mobility self-performance is documented as Total Dependent in current week and Extensive Assistance in prior week, Bed Mobility ADL has declined and an X is displayed.
- Example: If Bed Mobility self-performance is documented as Extensive Assistance in current week and Total Dependence in prior week, Bed Mobility ADL has not declined and cell is blank.
- Repeat same steps for Transfer and Toileting.

***≥3 Behaviors*.** If three or more different behaviors are documented for a resident during the current week, the number of behaviors is displayed.

- If any behaviors are new or different from prior week, the number of behaviors is displayed with an asterisk.
- Behavior only has to be documented once per shift to be included in the count.

***Worsening Pressure Ulcer*.** If the nurse specifies that the wound appears worse from the previous wound assessment.

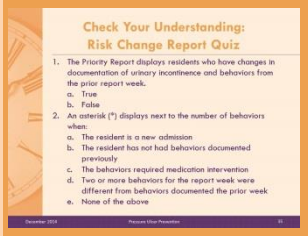
***New Pressure Ulcer*.** If the resident has a newly identified pressure ulcer during current week.

- Documentation is captured from weekly wound assessment documentation.
- Wound assessment must have assessment date during the report week.

Acute Change in Status. If the resident has experienced an acute change in status, noted on a change in condition report or other vendor-specific document.

Slide

Slides 35–36: Check Your Understanding: Risk Change Report Quiz



Slide

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.

Slide 35

1. The Risk Change Report displays residents who have changes in documentation of urinary incontinence and behaviors from the prior report week.

   a. True
   b. False (displays increases in incontinence only and new behaviors)

   ANSWER: b

2. An asterisk (*) displays next to the number of behaviors when:

   a. The resident is a new admission
   b. The resident has not had behaviors documented previously
   c. The behaviors required medication intervention
   d. Two or more behaviors for the report week were different from behaviors documented the prior week
   e. None of the above

   ANSWER: b

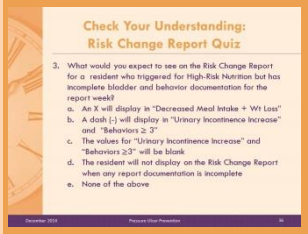
Slide 36

3. What would you expect to see on the Risk Change Report for a resident who triggered for High-Risk Nutrition but has incomplete bladder and behavior documentation for the report week?

   a. An X will display in "Decreased Meal Intake + Wt Loss"
   b. Dash (-) will display in "Urinary Incontinence Increase" & "Behaviors ≥ 3"
   c. "Urinary Incontinence Increase" and "Behaviors ≥3" will be blank
   d. The resident will not display on the Priority Report when any report documentation is incomplete
   e. None of the above

ANSWER: a, b

Note: Use additional questions and exercises located in the handout with facilitator trainees, if needed.

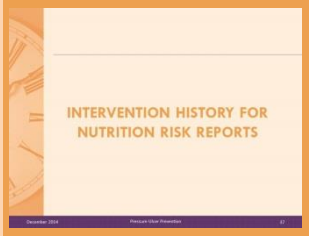


Slide

Slide 37: Intervention History for Nutrition Risk Reports title slide

SAY:

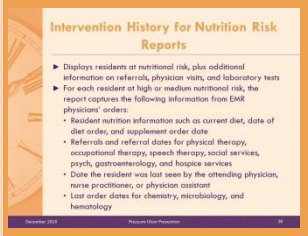
Let us now move to the next set of reports, the Nutrition Risk Reports.



Slide

Slide 38: Intervention History for Nutrition Risk Reports

SAY:



Slide

The Intervention History for Nutrition Risk Report displays residents at nutritional risk plus additional information on referrals, physician/nurse practitioner (NP)/physician assistant (PA) visits, and laboratory tests. Each report provides a history of interventions for residents at nutritional risk and "tells a story" that a clinician can use to consider next steps.

In reviewing the report, the clinician can easily see what has been done and when; likewise, the clinician can easily see what has never been ordered. Having these dates at hand eliminates the need for the clinician to manually review the medical record in search of prior interventions for nutrition risk.

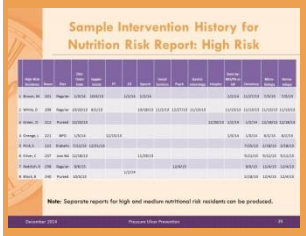
This report can be generated for the residents on the Nutrition High or Medium Risk Reports. For each resident at high or medium nutritional risk, the report captures the following information from EMR physician orders:

- Resident nutrition information such as current diet and date of diet order, and supplement order date;
- Referrals and referral dates for physical therapy (PT), occupational therapy (OT), speech therapy, social services, psych, gastroenterology, and hospice services;
- Date the resident was last seen by the attending physician, NP, or PA; and
- Last order dates for chemistry, microbiology, and hematology.

Information on the resident's current diet, how long the resident has been on the current diet, the presence or absence of supplements, the time that has passed since the last consults for PT, OT, or speech therapy, or if consults were ever obtained, all contribute to decision making and enhance care planning. Knowing the dates of latest lab orders, even without knowing the actual values, contributes to the nurse's ability to formulate a plan and focus next steps beyond followup assessment and chart review. Seeing what has been done, and when, helps staff consider what new actions are needed.

Note: If the EMR vendor is interfaced to lab information systems, then actual lab values can display.

Slide 39: Sample Intervention History for Nutrition Risk Report: High Risk



Slide

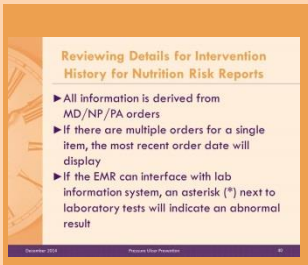
DO:

Instruct trainees to look at Intervention History for Nutrition Risk report handout. There are two reports: medium- and high-risk residents. The sample report is for high-risk residents. Review the report contents and point out special features.

	High-Risk Residents	Room	Diet	Diet Changes	Supple-ments	PT	OT	Speech	Social Services	Psych	Gastroent-erology	Hospice	Seen by MD/PA or NP	Chem-istry	Micro-biology	Hema-tology
1	Brown, M	201	Regular	1/3/14	10/4/13		1/2/14	1/2/14					1/2/14	11/27/13	7/3/13	7/3/13
2	White, D	209	Regular	10/20/13	9/2/13			10/18/13	11/2/13	12/27/13	11/13/13		11/13/13	11/13/13	11/13/13	11/13/13
3	Green, D	212	Pureed	12/23/13								12/30/13	1/2/14	1/2/14	12/18/13	12/18/13
4	Orange, L	221	NPO	1/5/14		12/15/13							1/3/14	1/3/14	6/2/13	6/2/13
5	Pink, S	222	Diabetic	7/22/13	12/31/13									7/25/13	2/18/13	2/18/13
6	Silver, C	237	Low NA	12/18/13				11/29/13						5/12/13	5/12/13	5/12/13
7	Reddish, R	238	Regular	9/6/13						12/4/13				9/6/13	12/4/13	12/4/13
8	Black, B	240	Pureed	10/3/13			1/2/14							2/18/13	12/4/13	12/4/13

N**ote:** The Intervention History for Nutrition Risk Report is a new report that was added in 2014. Only the report for the high-risk residents is shown. Separate reports for high and medium nutritional risk residents can be produced.

Slide 40: Reviewing Details for Intervention History Reports



Slide

DO:

Review the details with facilitator trainees.

SAY:

Let's review how the various fields are determined.

Diet. This is the physician's diet order. If the resident has an order for NPO, NPO will be displayed.

Diet Order Date. This is the date the physician's diet order was written. If the resident has an order for NPO, the date it was ordered will be displayed.

Supplements. This is the date that a supplement was ordered by the physician/NP/PA.

PT. This is the date that a physical therapy consult was ordered by the physician/NP/PA.

OT. This is the date that an occupational therapy consult was ordered by the physician/NP/PA.

Speech. This is the date that a speech therapy consult was ordered by the physician/NP/PA.

Social Services. This is the date that a social services consult was ordered by the physician/NP/PA.

Psych. This is the date that a psychiatric consult was ordered by the physician/NP/PA.

Gastroenterology. This is the date that a gastroenterology consult was ordered by the physician/NP/PA.

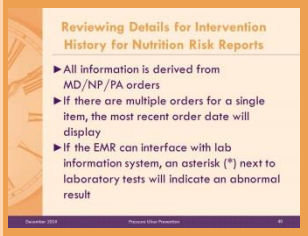
Hospice. This is the date that hospice services or a hospice consult was ordered by the physician/NP/PA.

Seen by MD/PA or NP. This is the last date that the resident was seen by a physician, nurse practitioner, or physician assistant. If a resident was seen multiple times, the report displays the date closest and prior to the date of the report.

Chemistry. This is the date of the most recent chemistry order. If the EMR has an interface to the lab information system, an asterisk (*) next to laboratory tests will indicate an abnormal result.

Microbiology. This is the date of the most recent microbiology order. If the EMR has an interface to the lab information system, an asterisk (*) next to laboratory tests will indicate an abnormal result.

Hematology. This is the date of the most recent hematology order. If the EMR has an interface to the lab information system, an asterisk (*) next to laboratory tests will indicate an abnormal result.

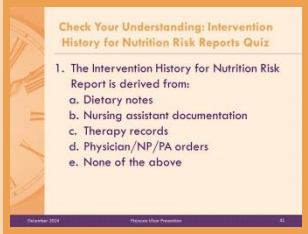


Slide

Slides 41–43: Check Your Understanding: Intervention History for Nutrition Risk Reports Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



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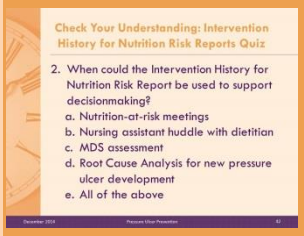


Slide 41

1. The Intervention History for Nutrition Risk Report is derived from:

   a. Dietary notes
   b. Nursing assistant documentation
   c. Therapy records
   d. Physician/NP/PA orders
   e. None of the above

   ANSWER: d

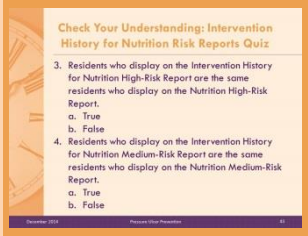
Slide 42

2. When could the Intervention History for Nutrition Risk Report be used to support decision making?

   a. Nutrition-at-risk meetings
   b. Nursing assistant huddle with dietitian
   c. MDS assessment
   d. Root Cause Analysis for new pressure ulcer development
   e. All of the above

   ANSWER: e

Slide 43



Slide

3. Residents who display on the Intervention History for Nutrition High-Risk Report are the same residents who display on the Nutrition High-Risk Report.

   a. True
   b. False

   ANSWER: a

4. Residents who display on the Intervention History for Nutrition Medium-Risk Report are the same residents who display on the Nutrition Medium-Risk Report.

   a. True
   b. False

   ANSWER: a

Note: Use additional questions and exercises located in the handout with facilitator trainees, if needed.

Slide 44: Resident Clinical, Functional, and Intervention Profile Report title slide

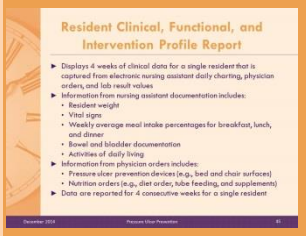
SAY:

Let us now move to the next report, the Resident Clinical, Functional, and Intervention Profile Report.

Slide

Slide 45: Resident Clinical, Functional, and Intervention Profile Report

SAY:



Slide

The Resident Weekly Clinical and ADL Functional Status Report displays 4 weeks of clinical data for a single resident that is captured from electronic nursing assistant daily charting, physician orders, and lab result values. Resident information is summarized and displayed in a useful format and eliminates the need to retrieve resident information from multiple electronic or paper sources.

Information from nursing assistant documentation includes:

- Resident weight.
- Vital signs.
- Weekly average meal intake percentages for breakfast, lunch, and dinner.
- Bowel and bladder documentation.
- Activities of daily living (ADLs).

Information from physician orders includes:

- Pressure ulcer prevention devices (e.g., bed and chair surfaces).
- Nutrition orders (e.g., diet order, tube feeding, and supplements).

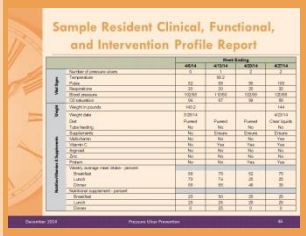
Trended data provide the clinician with an opportunity to spot subtle upward or downward trends that may not be apparent during daily or shift review. Trended clinical data may provide insights into why a pressure ulcer may not be healing. Quality improvement teams may want to access trended information to gain insight into the status of a resident in the 4 weeks leading up to pressure ulcer development.

Slide 46–48: Sample Resident Clinical, Functional, and Intervention Profile Report

DO:

Instruct trainees to look at Intervention History for Nutrition Risk report handout. Review the report contents and point out special features.

		Week Ending			
		4/6/14	4/13/14	4/20/14	4/27/14
Vital Signs	Number of pressure ulcers	0	1	2	2
	Temperature		99.2		
	Pulse	82	88	90	100
	Respirations	20	20	20	20
	Blood pressure	102/58	110/60	102/58	120/88
	O2 saturation	96	97	98	88
Weight	Weight in pounds	149.2			144
	Weight date	3/26/14			4/23/14
Nutrition/Vitamins & Supplements	Diet	Pureed	Pureed	Pureed	Clear liquids
	Tube feeding	No	No	No	No
	Supplements	No	Ensure	Ensure	Ensure
	Multivitamin	No	No	No	Yes
	Vitamin C	No	Yes	Yes	Yes
	Arginaid	No	No	No	No
	Zinc	No	No	No	No
	Protein	No	No	Yes	Yes
	Weekly average meal intake - percent				
	Breakfast	88	78	62	75
	Lunch	79	74	25	25
	Dinner	65	55	45	35
	Nutritional supplement - percent				
	Breakfast	25	50	25	25
	Lunch	25	25	25	25
	Dinner	0	25	0	0
Bowel	Habits	Continent	Continent	Incontinent	Incontinent
	Loose stool	No	No	Yes	Yes
	Incontinence				
	# shifts/week	0	0	12	18
	Daily incontinence				X
	3 days without BM		X		X
Bladder	Habits	Incontinent	Incontinent	Incontinent	Incontinent
	Catheter	Condom	No	No	Foley
	Ostomy	No	No	No	No
	Incontinence				
	# shifts/week	9	12	12	14
	Daily incontinence	No	No	Yes	Yes
	Did not void # shifts/week	0	0	0	1



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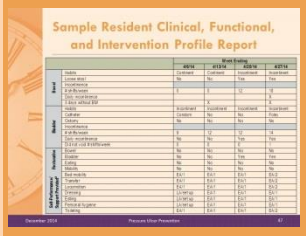

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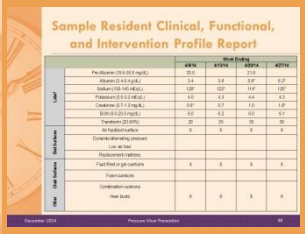
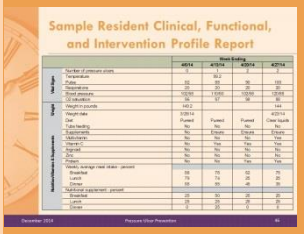


		Week Ending			
		4/6/14	4/13/14	4/20/14	4/27/14
Restorative	Bowel	No	No	No	No
	Bladder	No	No	Yes	Yes
	Eating	No	No	No	No
	Mobility	No	No	No	No
Self-Performance/Support Provided[2]	Bed mobility	EA/1	EA/1	EA/1	EA/2
	Transfer	EA/1	EA/1	EA/1	EA/2
	Locomotion	EA/1	EA/1	EA/1	EA/2
	Dressing	LA/set up	EA/1	EA/1	EA/1
	Eating	LA/set up	EA/1	EA/1	EA/1
	Personal hygiene	LA/set up	EA/1	EA/1	EA/1
	Toileting	EA/1	EA/1	EA/1	EA/2
Labs[1]	Pre-Albumin (19.5-35.8 mg/dL)	33.0		21.6	
	Albumin (3.4-5.4 g/dL)	3.4	3.6	5.8*	6.2*
	Sodium (135-145 mEq/L)	128*	122*	114*	120*
	Potassium (3.5-5.2 mEq/L)	4.0	4.3	4.4	4.3
	Creatinine (0.7-1.3 mg/dL)	0.6*	0.7	1.0	1.8*
	BUN (6.0-20.0 mg/dL)	6.0	6.2	6.0	6.1
	Transferrin (20-50%)	20	25	35	35
Bed Surfaces	Air fluidized surface	X	X	X	X
	Dynamic/alternating pressure				
	Low air loss				
	Replacement mattress				
Chair Surfaces	Fluid filled or gel cushions	X	X	X	X
	Foam cushions				
	Combination cushions				
Other	Heel boots	X	X	X	X



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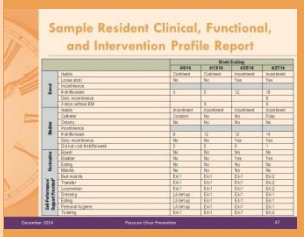

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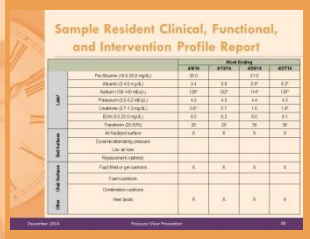
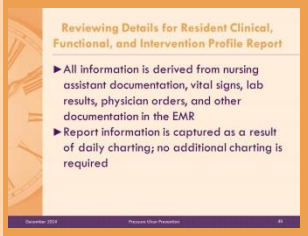


[1] Lab normal value ranges used by the facility in parentheses.* Indicates abnormal value.
[2] These abbreviations are based on MDS 3.0 ADL coding: Self-Performance—EA= extensive assistance; LA = limited assistance; and Total = total dependent; the abbreviation after the slash represents ADL support provided—set up=set up help only, 1 or 2 = how many staff provide physical assistance.

Slide 49: Reviewing Details for Resident Clinical, Functional, and Intervention Profile Report



Slide

DO:

Review the report details with facilitator trainees.

SAY:

All information is derived from nursing assistant documentation, vital signs, lab results, physician orders, and other documentation in the EMR. Report information is captured as a result of daily charting; no additional charting is required.

Let's review how the various fields are determined.

Vital Signs

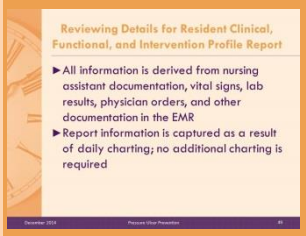
- ***Number of Pressure Ulcers.*** This is a count of unique pressure ulcers.
- ***Temperature.*** This is the temperature displayed in Fahrenheit or Celsius.
- ***Pulse.*** This is the pulse value.
- ***Respirations.*** This is the respiration value.
- ***Blood pressure.*** Systolic blood pressure over diastolic blood pressure.
- ***O2 saturation.*** This is the oxygen saturation percentage.

Weight

- ***Weight in pounds.*** Displays weight value in pounds.
- ***Weight date.*** Displays weight date of lowest weekly weight value.

Nutrition/Vitamins & Supplements

- ***Diet.*** Displays physician's order for diet.
- ***Tube Feeding.*** Displays an X if there is a physician order for tube feeding.

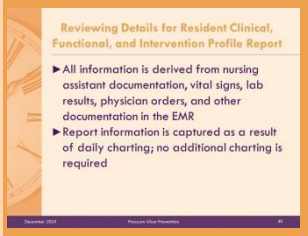


Slide

- ***Supplements.*** If there is a physician order for a supplement, the name of the supplement is displayed.
- ***Multivitamin.*** If there is a physician order for a multivitamin, "Yes" is displayed.
- ***Vitamin C.*** If there is a physician order for vitamin C, "Yes" is displayed.
- ***Arginaid.*** If there is a physician order for Arginaid, "Yes" is displayed.
- ***Zinc.*** If there is a physician order for zinc, "Yes" is displayed.
- ***Protein.*** If there is a physician order or a dietitian recommendation to add protein as a supplement, "Yes" is displayed.
- Weekly average meal intake – percent
    - ***Breakfast.*** Displays average meal intake as a percentage.
    - ***Lunch.*** Displays average meal intake as a percentage.
    - ***Dinner.*** Displays average meal intake as a percentage.
- Nutritional Supplement – percent
    - ***Breakfast.*** Displays average supplement intake as a percentage,
    - ***Lunch.*** Displays average supplement intake as a percentage,
    - ***Dinner.*** Displays average supplement intake as a percentage.

Bowel

- ***Habits***. If any bowel incontinence is documented during the report week, then "Incontinent" is displayed; if no bowel incontinence, "Continent" is displayed.
- ***Loose Stool.*** If any loose stool is documented during the report week, "Yes" is displayed.
- Incontinence
    - ***# shifts/week.*** Displays a count of the number of shifts bowel incontinence was recorded during the report week.
    - ***Daily incontinence.*** If bowel incontinence is documented on at least one shift each day during the report week, "Yes" is displayed.
- ***3 days without BM.*** If no bowel movement is recorded for consecutive shifts over 3 days, then an X is displayed.



Slide

Bladder

- ***Habits.*** If any bladder incontinence is documented during the report week, then "Incontinent" is displayed; if no bladder incontinence, "Continent" is displayed.
- ***Catheter.*** If a Foley or external catheter is used during the report week, type of catheter is displayed.
- ***Ostomy.*** If an ostomy is used during the report week, "Yes" is displayed.
- Incontinence
    - ***# shifts/week.*** Displays a count of the number of shifts bladder incontinence was recorded during the report week.
    - ***Daily incontinence.*** If bladder incontinence is documented on at least one shift each day during the report week, "Yes" is displayed.
- ***Did not void # shifts/week.*** Displays a count of the number of shifts "did not void" was recorded.

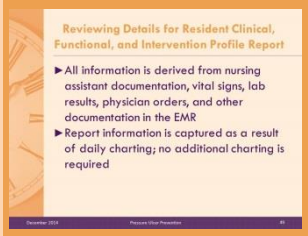
Restorative

- ***Bowel.*** Displays "Yes" if a restorative program for bowel is in place.
- ***Bladder.*** Displays "Yes" if a restorative program for bladder is in place.
- ***Eating.*** Displays "Yes" if a restorative program for eating is in place.
- ***Mobility.*** Displays "Yes" if a restorative program for mobility is in place.

Self-Performance/Support Provided

This is the resident's level of self-performance and support for bed mobility, transfer, locomotion, dressing, eating, personal hygiene, and toileting. For both self-performance and support, the highest level or most dependent value is recorded for the report week. Self-performance and support are reported separated by a slash.

- Self-performance responses are:
    - Independent (IN)
    - Supervision (SU)
    - Limited Assistance (LA)
    - Extensive Assistance (EA)
    - Total Dependence (Total)
    - Activity did not occur (NO)



Slide

- Support responses are:
    - No setup (None)
    - Setup only (Set up)
    - One person (1)
    - Two persons (2)
    - Activity did not occur (NO)

Labs

Displays the value closest and prior to the report ending date for the report week of the following labs:

- Pre-Albumin.
- Albumin.
- Sodium.
- Potassium.
- Creatinine.
- BUN.
- Transferrin.

An asterisk is displayed for abnormal values.

Bed Surfaces

Displays an X if there is a physician's order for the following bed surfaces:

- Air fluidized surface.
- Dynamic/alternating pressure.
- Low air loss.
- Replacement mattress.

Chair Surfaces

Displays an X if there is a physician's order for the following chair surfaces:

- Fluid-filled or gel cushions.
- Foam cushions.
- Combination cushions.

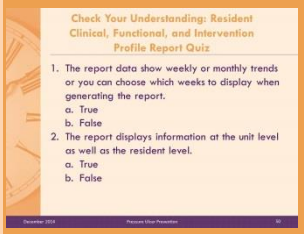
Other

- Displays an X if there is a physician's order for heel boots.

Slides 50–51: Check Your Understanding: Resident Clinical, Functional, and Intervention Profile Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



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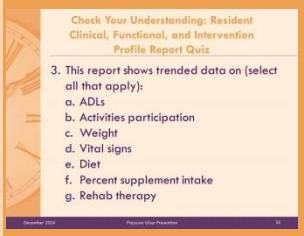


Slide 50

1. The report data show weekly or monthly trends or you can choose which weeks to display when generating the report.

   a. True
   b. False

   ANSWER: b

2. The report displays information at the unit level as well as at the resident level.

   a. True
   b. False

   ANSWER: b

Slide 51

3. This report shows trended data on (select all that apply):

   a. ADLs
   b. Activities participation
   c. Weight
   d. Vital signs
   e. Diet
   f. Percent supplement intake
   g. Rehab therapy

   ANSWERS: a, c, d, e, f

Slide 52: Completeness Report title slide

SAY:

Let us now move to the final report, the Completeness Report.

Slide

Slide 53: Completeness Report (Optional)

SAY:

Slide

The Completeness Report is an optional report. It verifies nursing assistant documentation to confirm that the documentation is complete enough to run the report calculations and generate the reports. On-Time reports will not generate unless at least 75 percent of the documentation is available. Since most long-term care EMRs provide a mechanism for users to monitor completion of nursing assistant documentation, this report is offered as an optional report. Nursing homes implementing On-Time should check the completeness of the nursing assistant documentation either using a process within their EMR or through the use of this report.

All On-Time reports are generated from four sections of nursing assistant documentation. The Completeness Report is available at the facility, unit, or shift level and covers documentation of:

- Meal intake.
- Bowel.
- Bladder.
- Behavior.

Note: In some facilities, nursing assistants do not document behaviors, so the behavior section may be blank or the EMR vendor may omit those columns from the report display.

Slides 54–57: Sample Completeness Reports: By Facility and By Shift

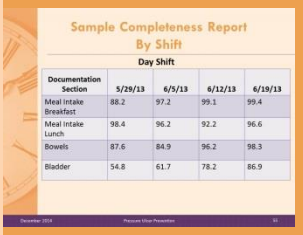
DO:

Instruct trainees to look at the Sample Completeness Report handout. Review report contents and point out special features.


Sample Completeness Report: Facility Level

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake	92.2	93.1	90.4	92.0
Bowels	67.6	74.9	66.2	58.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide


Sample Completeness Report By Shift
Day Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake Breakfast	88.2	97.2	99.1	99.4
Meal Intake Lunch	98.4	96.2	92.2	96.6
Bowels	87.6	84.9	96.2	98.3
Bladder	54.8	61.7	78.2	86.9

Slide


Sample Completeness Report By Shift
Evening Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake Dinner	90.0	92.0	80.0	80.0
Bowels	97.6	94.9	96.2	98.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide


Sample Completeness Report By Shift
Night Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Bowels	67.6	64.9	66.2	58.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide 54: Sample Completeness Report: Facility Level

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake	92.2	93.1	90.4	92.0
Bowels	67.6	74.9	66.2	58.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide 55: Sample Completeness Report by Shift
Day Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake Breakfast	88.2	97.2	99.1	99.4
Meal Intake Lunch	98.4	96.2	92.2	96.6
Bowels	87.6	84.9	96.2	98.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide 56: Sample Completeness Report by Shift
Evening Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Meal Intake Dinner	90.0	92.0	80.0	80.0
Bowels	97.6	94.9	96.2	98.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide 57: Sample Completeness Report by Shift
Night Shift

Documentation Section	5/29/13	6/5/13	6/12/13	6/19/13
Bowels	67.6	64.9	66.2	58.3
Bladder	54.8	61.7	78.2	86.9
Behaviors	53.1	69.9	87.1	91.0

Slide 58: Reviewing Calculation Details for Completeness Report

DO:

Review the calculation details with facilitator trainees.

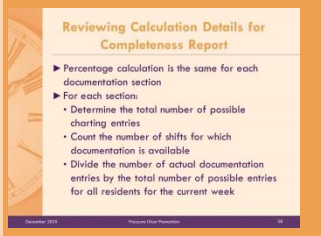
SAY:

The percentage calculation is the same for each documentation section. For each section, determine the total number of possible charting entries. Count the number of shifts for which documentation is available. Divide the number of documentation entries by the total possible entries for all residents for the current week. The value displays as a percentage.

For example:

At the shift level, on the 7 to 3 shift there should be documentation for two meals (breakfast and lunch) for each day of the week (14 possible entries). If only 7 entries are found, the completion rate is 50 percent.

See Nutrition Report Calculation Details (Slide 10) for how NPO and Not Available for Meal are addressed.

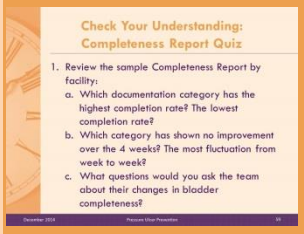


Slide

Slides 59–60: Check Your Understanding: Completeness Report Quiz

DO:

Ask participants to answer the quiz questions independently and then discuss as a group.



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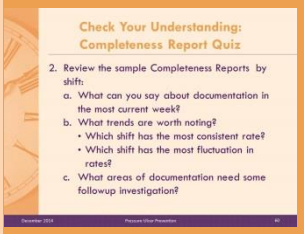

Slide 59

1. Review the sample Completeness Report by facility:

    a. Which documentation category in the current week has the highest completeness rate? The lowest completion rate?
    b. Which category has shown no improvement over the 4 weeks? The most fluctuation from week to week?
    c. What questions would you ask the team about their changes in bladder completeness rates?

ANSWERS:

a. Meal intake - highest; Bowels - lowest
b. Bowels - no improvement; Behaviors - most fluctuation
c. To what do they attribute these changes? Did they provide in-servicing, coaching? Do they believe these results?

Slide 60

2. Review the sample Completeness Reports by shift:

    a. What can you say about documentation in the most current week?
    b. What trends are worth noting?

        - Which shift has the most consistent rate?
        - Which shift has the most fluctuation in rates?

    c. What areas of documentation need some followup investigation?

        - Current week documentation is above 75 percent in every category except Bowels.
        - Day shift is the most consistent; evening shift has the most fluctuation.
        - Behaviors and Bladder documentation for day, evening, and night shift are identical. Are they copying each other?