When skilled treatment ends, however, resident care does not. Restorative nursing programs are intended to maintain, if not improve, a resident’s level of functioning. In reducing the likelihood of a resident’s decline, which may result in a return to rehab treatment—or, worse, the hospital—restorative programs serve as a crucial aspect of resident care.

"Restorative is a long-term process—working with people for more hands-on due to changes in their makeup or loss of function—and that’s primarily nursing," says Elizabeth Malzahn, national director of healthcare for Covenant Retirement Communities in Skokie, IL. “It's more maximizing and maintaining function than actually fixing something that’s broken.”

With a primary focus on therapy, the relationship between rehab and restorative may become fractured, when in reality they ought to be intimately linked. The two must play off each other if a facility is to provide the best possible care to its residents, Malzahn explains. “One can’t replace the other. You can’t have rehab instead of restorative and you can’t have restorative instead of rehab. They have to complement each other,” she says. “The highest level of functioning for residents is following rehab, so you need to have that active restorative program to be able to maintain what they’ve retrained and relearned in the rehabilitative program.”

In most cases, it’s unbalanced reimbursement that drives a wedge between the two, according to Bonnie Foster, RN, BSN, M.Ed., a long-term care consultant in Columbia, SC, who acknowledges the importance of getting paid for skilled services, but says resident care should remain priority one.
And without a robust restorative program, facilities risk diminishing that care, she says. For example, if therapy works with a resident for three weeks and is able to get the individual walking again, only to see the resident back in a wheelchair for no apparent reason once therapy ends, that effort—along with the resident’s maximized function—is wasted. In addition, surveyors could cite the facility under F309 for the resident’s decline, Foster says.

The threat of an F-tag should be enough to persuade any facility to reexamine its restorative nursing program. In doing so, know that it is absolutely possible to build a robust program despite a lack of resources and limited financial incentives.

**Moving beyond ‘bare bones’**

Nearly every SNF would answer “yes” if asked whether a restorative program is offered. But how many of those facilities would be proud enough of their program to share it with others?

“When you really break it down and take a look at what a facility is doing for its restorative program, it’s very bare bones,” says Malzahn. “It’s not taking that handoff from therapy, from the rehab piece, and taking it another step to maintain and maximize that function. It’s very basic, and I think there’s so much more that can be done with restorative programs.”

Taking that next step can be as simple as reviewing current programs in use, such as toileting. If you’re retraining a resident for continence maintenance, don’t stop at simple cues every 120 minutes to use the restroom.

“Does that help with bladder retraining or an incontinence program? Yes. But can we really call that restorative?” says Malzahn.

If equipment is available, such as an ultrasound machine, use that to measure a resident’s bladder content, she advises. In determining the root of the problem, facilities can more aptly refine a restorative program and improve a resident’s quality of life.

Malzahn concedes that for stand-alone facilities, it may be extremely overwhelming to develop a robust restorative program given the lack of funding.

“That’s certainly one of the biggest challenges. There really is no direct reimbursement for restorative nursing, so it’s the last kid picked. You have to take care of all these other things, and where restorative is extremely important, it ends up being left out,” she says. “Should it be a focus? Absolutely. But it’s not like there’s an endless supply of money to fund it either.”
The general lack of reimbursement means facilities need to be very purposeful with the programs they choose to implement. It also means they should rely on restorative support from a wide range of staff members.

Making it a team effort

One common form of restorative program organization is to select one or two licensed nurses to serve as restorative aides. (As mandated by federal law, a licensed nurse must oversee a SNF’s restorative program; individual states can require the specific use of an RN or LPN.)

But this method may be holding your restorative program back, especially if restorative aides are pulled from the program on days when they’re needed to fill in on the floor, Foster says.

Instead, a restorative program needs to build off of rehab and include the efforts of multiple staff members, not just nursing, she adds.

“Therapy is therapy. That’s a skilled service and once it’s done, it’s done. Forget about it,” says Foster. “You don’t need a doctor’s order for restorative, so do it through the care plan. Sit down in the care plan process and see if it should go through activities, dietary, or social services. Make it truly interdisciplinary.”

The first step is training all CNAs so they’re involved in each resident’s restorative program. That way, if the restorative aide is not present, a number of other frontline staff members can step in.

“You really have a lot of opportunity to capitalize on strengths if you’re moving people around and assigning residents to different staff,” says Malzahn. “Everybody needs to know how to contribute and make it part of the resident’s routine. That’s where it’s more successful because those staff members get to know the residents and the residents get to know them in the other facets of their life, not just as being dedicated to that restorative function.”

Taking advantage of the MDS

As Foster suggested, a number of disciplines outside of nursing should contribute to a restorative program, the most essential of which could very well be activities.

“Everything has to be on the MDS or it doesn’t count,” she says. “You have this huge activity program where the residents do exercises and use the Wii®. These activities are fun and they’re also therapeutic, but there’s no explicit place on the MDS to put them. However, if you put it under, for example, range of motion in Section O, then all of a sudden these activities can count on restorative.”

This is another example of taking that next step—empowering residents and formalizing your program through documentation and the care plan.

Your restorative nursing program can use other aspects of the MDS 3.0 to its advantage. In gaining an understanding of resident preferences in Section F, facilities are able to further expand on program offerings and focus. In the near future, this will likely become even more vital to restorative nursing.

“I think that with healthcare reform and as we start to be measured more on our outcomes, having a strong restorative program is going to be a huge component because you’re showing that you’re committed to maintaining and maximizing resident function, which has the potential to reduce residents’ need to go into the hospital or return to heavy therapy,” says Malzahn. “I think it’s something that is going to become more and more expected.”

In building toward that goal, remember that an appreciation of the big picture is necessary. Although devoting resources may be difficult from a financial perspective, maintaining or implementing a robust restorative program should fall near the top of every SNF’s to-do list given the pivotal clinical benefits provided to residents.
Communication and collaboration: IDT best practices

The goal at all SNFs should be the same: provide the best possible care to each and every resident in the building. Different facilities will have their own methods for achieving that goal, but a number of constants exist, namely the pivotal role played by the interdisciplinary team (IDT) and the need for consistent collaboration among the team’s members.

While each team member has his or her own resident care responsibilities, it is important to remember that those responsibilities are tied to the tasks of others, in addition to the PPS reimbursement process. For that reason, IDTs must develop communication policies and procedures that will facilitate honesty and directness, as well as foster respect and teamwork.

Such an undertaking rests with the MDS coordinator, says Holly Sox, RN, BSN, RAC-CT, MDS coordinator at Presbyterian Communities of South Carolina in Lexington.

“I am a sports fan, so sports metaphors come easily to me. I see the MDS coordinator as the quarterback and captain of the interdisciplinary team. While all team members are vital to the function of the team and the assessment process, without a strong leader, the team will fall apart like my favorite college team does in the biggest games,” Sox says. “You have to know who’s on the field at all times. You have to know what your resources are and be willing to ask for help when you need it.”

Knowing who’s on the field means maintaining a system for tracking admissions, discharges, and transfers so that discharge assessments and entry tracking forms can be completed promptly, says Sox.

This can be overwhelming at times, so MDS coordinators can’t be afraid to rely on other team members when necessary, especially the DON. In many cases, an IDT is only as strong as the MDS coordinator and DON’s relationship, which must encompass a great deal of trust and respect.

“I’m a nurse first and foremost, and I think that in working side by side with the DON and assistant DON, I’m able to offer support and provide information that they need so they can do their jobs,” says Sox.

DONs and assistant DONs should reciprocate this attitude and provide MDS coordinators with the help and clinical information they need in order to complete their responsibilities with greater efficiency.

In addition, for DONs who supervise the MDS coordinator, it is important to recognize that in many cases, micromanaging becomes counterproductive. MDS coordinators are typically burdened with a lengthy list of responsibilities, so having to worry about those tasks under the watchful and untrusting eye of a DON—or any other manager, for that matter—can put undue stress on the MDS coordinator and result in missteps or errors that may otherwise not occur.

The same mentality needs to be held by the MDS coordinator in working with therapists, nurses, CNAs, and other members of the IDT, says Sox.

“You can’t expect total subservience because it won’t work that way. These are all professionals who have an expertise,” she says. “To go back to the football analogy, if I’m on the field and I want to throw a pass, I need to count on my receiver to catch the ball; I can’t go catch it. I need to have trust in the people who are working with me and I need to treat them that way, because the team would just fall apart otherwise.”

Following a few simple best practices will allow your IDT to thrive, and thus improve the overall care of your facility’s residents.
The benefit of efficient meetings

IDT staff members are quite familiar with weekly meetings, which are commonplace at most facilities. But how many staff members can honestly say that they are gaining valuable information from those meetings or that the time is being used efficiently and the issues discussed are resolved or instituted effectively?

Weekly meetings are absolutely necessary; however, facilities should aim to get the most productivity as possible out of every meeting.

Various IDT staff members should be actively participating in at least three types of meetings:
- A weekly Medicare meeting
- A weekly IDT/care plan meeting
- A brief, daily morning meeting

The weekly Medicare meeting is an opportunity for the IDT to review each resident and discuss his or her individual needs related to the skilled services being provided. Staff members can take this time to improve resident outcomes through a coordinated system of care delivery. The following IDT members should be present at the weekly Medicare meeting:
- MDS coordinator or RN assessment coordinator
- Nursing representative (usually the DON or assistant DON)
- Therapy representative
- Social services
- Accounting/billing
- Medical records
- Other frontline staff, if needed, to discuss specific resident care concerns

Prior to the meeting, each discipline should prepare any necessary materials, which may include:
- The MDS coordinator’s list of outstanding signatures required for assessment submissions
- Nursing’s notes, discharge plans, and current medical statuses for residents
- Therapy’s equipment needs and resident progress
During the Medicare meeting, each resident record should be reviewed in detail. This is often a good time to perform triple checks. Keep in mind that while nursing and therapy will occupy most of the discussion during the Medicare meeting, it is a venue for all disciplines and is critical to the success of your facility’s Medicare program.

Just like the Medicare meeting, an IDT or care plan meeting should be held once a week in the same (or at least a similar) time slot. A substantial portion of the meeting should be devoted to devising or revising resident care plans with contributions from family members. While the MDS coordinator typically chairs the IDT/care plan meeting, the DON, who communicates directly with busy frontline staff members, should play an active role.

“The director of nursing communicates with and represents the nurses since it’s very difficult for them to take time to be there,” says Joyce Gregory, RN, DSD, MDS coordinator at Sierra View Homes in Reedley, CA.

“The director of nursing is extremely helpful. She’s on the floor and is observing. I’m swamped with paperwork, but she’s out there and is very aware of what’s going on with the residents. She’ll be helping the CNAs or out with the nurses checking on things. She’s a hands-on person and it’s very nice to have that kind of connection.”

It’s that kind of working relationship that will keep an IDT on the right track and establish an agenda for the IDT/care plan meeting.

“The director of nursing and I, we’re crossing paths frequently throughout the day and sharing with each other what’s happening with our residents, so we have an idea of what has to be done,” says Gregory.

As is the case with the Medicare meeting, efficiency increases when key parties or disciplines go into the IDT/care plan meeting with set items to discuss. Some of those items will be unique on a week-to-week basis; others will be a constant part of the agenda.

“We tend to go through our MDS assessments. We usually have four to five that are scheduled per meeting and we use about 15 minutes per resident with the family members when they come in,” says Gregory. “We go through the care plan with the family and we involve CNAs and the director of nursing. As a team, we review the plan of care and see if we need to make any changes or problem solve.”

The daily morning meeting, often called a stand-up meeting, can be viewed as a less formal combination of the Medicare and IDT/care plan meetings. They should not last long, usually about 15 minutes at the most, but are very worthwhile in communicating important information to the IDT.

“We go over the 24-hour report from the day before with all of the clinical information. We go over the MDS calendar to see what’s on the agenda for the day. We look to see if there have been significant changes to determine if a significant change in status assessment needs to be done,” says Sox.

**Appropriate e-mail communication**

In addition to serving as a daily catch-up, the morning meeting is a good time to make any necessary administrative announcements, such as changes to other meeting schedules, out-of-office notifications, or a listing of agenda items for meetings to be held later in the day.

Some facilities find it best to share these announcements and other IDT information over e-mail instead, which is perfectly acceptable. In using e-mail as a means of communication for the IDT, the key is to maximize effectiveness without overrelying on the technology. Despite the convenience of e-mail, many conversations are best suited for face-to-face interaction, and these should not be diminished or replaced.

“We tend to do a lot of face-to-face. I use e-mail for a number of the staff that are not in the IDT, although, with...
the IDT, I do communicate things like changes to assessments in an e-mail to IDT members who have input with the assessments,” says Gregory. “E-mail has its place, but I also find that face-to-face is extremely valuable.”

The amount of e-mail communication used between members of the IDT, as well as other staff, is often tied to the size of a facility. Gregory’s Sierra View Homes (59 beds) and Sox’s Presbyterian Communities of South Carolina (44 beds) are in the same size range.

Still, Sox says she finds e-mail to be extremely helpful when it comes to quick exchanges and mass communication, such as sending out weekly calendars to the IDT so that staff members know what they need to get done and can plan ahead. In fact, Sox says she uses e-mail more often now than at the larger facility she worked in previously, which just goes to show that use of the technology should be unique to the routines and needs of each facility.

**Organization as an IDT priority**

Even the best communication efforts—whether through e-mail, in face-to-face conversations, or during meetings—are all for naught if an IDT is not organized.

Think of organization as a prerequisite to efficient collaboration. It is the engine of the IDT vehicle. Without it, the other moving parts can only inch along at a snail’s pace. Like an engine, organization is absolutely necessary for the highest levels of function to occur.

IDT teams—and in many cases, specifically the MDS coordinator—can facilitate organization in a number of ways.

A system for managing daily work is essential. A calendar, spreadsheet, or tracking tool can be used for keeping tabs on assessments. If operating in freehand, assessment reference dates (ARD) should be written in pencil, allowing for easy edits should the ARD change.

It’s helpful to prioritize the daily workload by first completing items that are time sensitive—such as interviews, Care Area Assessments, and care plans—then tackling the OBRA assessments that are due, and lastly completing PPS assessments.

If the MDS coordinator and DON are organized, it should rub off on the remaining IDT members, each of whom should maintain calendars to track when assessments and care plans are due. All calendar updates should come from the MDS coordinator in order to ensure consistency.

Shift reports, completed by the nurses, are also a great way to keep everyone on the same page. “It helps with inter-shift communication,” Gregory says. “The director of nursing and I go and check them out to see what might help us. Charge nurses are aware that they can connect with us about any issues that are going on. For us, a lot of it is verbal interaction. If we have a concern, we tend to put our heads together rather often to try and decide how to address issues.”

CNA card systems are also helpful in communicating care plans to frontline staff.

“For the staff, morale is key. People know when the team isn’t functioning well and it filters down to the direct care staff,” says Sox. “One of things we use here is a CNA plan of care that goes in the closet for each resident. We as the interdisciplinary team need to prepare a good care plan and then get that communicated to the staff members who are out there providing the care. And if we’re not doing our job, then they’re not going to have the information they need. That gets frustrating, especially if they’re held accountable.”

Remember that organization paces collaboration, which an IDT must employ through steady communication in order to provide optimal resident care. “If we’re not keeping up with each other, then important things get missed,” says Sox.
MedPAC recommends significant payment cuts

Editor’s note: This article originally appeared in the April issue of Billing Alert for Long-Term Care.

In January 2012, the Medicare Payment Advisory Commission (MedPAC) voted to recommend significant changes to the way skilled nursing providers are paid by the government through Medicare.

Despite protests by providers in late 2011, when the recommendation was proposed, MedPAC unanimously voted to advocate that:

➤ Congress eliminate the next fiscal year’s (FY) market basket update and direct the Secretary of the U.S. Department of Health and Human Services (HHS) to revise the PPS for SNFs in FY 2013.

➤ Rebasings should begin in FY 2014, with an initial reduction of 4% and subsequent reductions over an appropriate transition period until Medicare’s payments are “better aligned with providers’ costs.”

➤ Congress should direct HHS to cut payments to SNFs with relatively high risk-adjusted rehospitalization rates for their Medicare-covered stays.

“MedPAC’s recommendations follow multiple significant changes to reimbursement in recent years. The payment inconsistencies have us all concerned about the impact on quality of care,” says Frosini Rubertino, RN, CPRA, CDONA/LTC, executive director at Training in Motion, LLC, in Bella Vista, AR. “We are obviously still navigating through reform.”

Why the drive for rebasing?

The results of a MedPAC analysis of freestanding SNF Medicare cost report data show that the collective Medicare margin for freestanding SNFs was 18.5% in 2011.

Using this study to define a group of relatively efficient SNFs—with costs that were 10% lower, community discharge rates that were 38% higher, and rehospitalization rates that were 17% lower over a three-year period as compared to other SNFs—the commission modeled revenues and costs of this group to project an average margin of 14.6% in 2012.

Based on this data, MedPAC suggests there is the need to rebase payments because:

➤ The projected margin for 2012 continues the trend of double-digit margins in this sector since 2000, indicating that the PPS has exerted too little fiscal pressure on providers

➤ The variation in Medicare margins is not explained by differences in patient mix

➤ Cost differences are not explained by differences in wage levels, case mix, or beneficiary demographics

➤ Some SNFs have both low costs and high quality

➤ Some Medicare Advantage payments are considerably lower than fee-for-service payments

Given the data and resulting suggestions, the commission acknowledged three key concerns that were raised about rebasing:

1. Medicare’s payments were already reduced by 11% in 2012. Even after the reductions, MedPAC estimates margins will be over 14% in 2012. “It’s the same thing we’ve been hearing for a while,” says Janet Potter, CPA, MAS, manager of healthcare research at Frost, Ruttenberg & Rothblatt, PC, in Deerfield, IL. “They say SNFs have too high a profit margin for Medicare.”

2. Some argue that facilities need high payments from Medicare to finance low payments from Medicaid. “They do recognize that this profit margin is used to offset Medicaid costs, but they don’t seem to take this into consideration,” Potter says. “They continue to tell SNFs to cut costs in other ways.”

3. The variation in Medicare margins could mean that some SNFs would fare poorly with rebased payments. While the average Medicare margin for 2010 was 18.5%, there was significant variation in costs across facilities.
“In order to remain committed to our Nursing Home Quality Initiative efforts and Advancing in Excellence in America’s Nursing Homes campaign, providers will need to take a closer look at our current systems to thrive with a lower operating margin,” says Rubertino. 

**What are your options?**

Should Congress accept these recommendations, the facilities that will succeed are those that have been proactive in their efforts to prepare, according to Potter. The following are some tactics your facility can implement right away:

➤ **Establish a buffer account.** There aren’t many ways for SNFs to cut overhead costs within a facility without compromising the quality of care for residents. Facilities must look for creative ways to reduce costs, should these recommendations be accepted. If you haven’t done so already, now is the time to set aside money for future, unexpected expenses.

➤ **Develop strong orientation and employee retention programs.** “Delivering better care with consistent staff that possesses stronger clinical skills can help lower operating costs and result in more payment incentives,” says Rubertino.

➤ **Build stronger relationships with your community and its resources.** Doing so will allow your facility to build a quality census and referral base.

➤ **Improve customer service.** Strengthening your customer service efforts will have a positive impact in improving a resident’s overall experience and attitude toward treatment.

Facilities should also work with associations in lobbying efforts. “Local and state associations closely follow state-specific Medicaid issues, including reimbursement, and will have action plans in place,” Potter says. “If their ability to fund Medicaid through Medicare margins is taken away, it will have a drastic impact on the survival of many SNFs.”

There are many associations SNFs can partner with in these efforts. For example, American Health Care Association President Mark Parkinson affirmed his group’s stand against rebasing pay rates in a recent statement:

> *We do not support rebasing. Moving forward, however, Congress can and should seriously consider the multiple changes that have already been made in the payment process in recent years … Our centers are still adjusting, and will need more time before we can understand what these changes will mean to our overall economic health in the coming years.*

“This is something that has been talked about for a while, and while we may not want it to happen, there is a good chance it will,” Potter says.

Facilities should use the time available to prepare for whatever may come in the future.

**Rehospitalization rates will be key**

A reduction of unnecessary rehospitalizations is something many SNFs focus on, and unlike a spending cut, SNFs will have greater control over these rates, says Potter.

According to MedPAC, the goals of a policy to discourage rehospitalization are to:

➤ Improve the care beneficiaries receive in SNFs
➤ Improve transition care
➤ Lower program spending on rehospitalizations that could have been averted

The recommended policy raises some notable concerns that may have a negative financial impact on SNFs struggling to reduce their rehospitalization rates. A primary fear is the assignment of fault under the rehospitalization policy, which states:

➤ If a rehospitalization occurred within 30 days of discharge from the hospital, both the hospital and the SNF would be at risk.

➤ If the rehospitalization occurred on day 31, only the SNF would be at risk. The goal here is to ensure quality transition between providers.
➤ After the beneficiary is discharged from the SNF, the SNF would be at risk for rehospitalization that occurred within 30 days—to ensure successful transitions after the SNF stay.

“The most difficult thing to control is that once residents are discharged from SNFs, the SNFs are still responsible,” Potter says. “Facilities need to place an even greater emphasis on preparing residents for a transition back to their lives outside of the facility and on communication with residents and caregivers after discharge.”

### Take control with your facility

MedPAC stresses the importance of using a rate to gauge performance over multiple years to avoid a focus on individual cases and to ensure that providers are not penalized for having a bad year. That being said, it is critical for SNFs to recognize the importance of transitions—whether from a hospital to a SNF or from a SNF to the resident’s home—with each resident.

Ensure that your facility is on the right track, limiting serious clinical and financial risks, by using the following tips:

➤ **Strengthen communication with hospitals.**
Open communication with hospitals will promote a smoother transition to the facility. Confirm with hospital contacts that all necessary discharge information has been gathered and transferred to the facility.

➤ **Train clinical staff.** Adequate training on how to discharge residents is critical in ensuring that residents understand and are comfortable with transitioning back to their daily lives. Improve staff skills on managing acute and chronic conditions to decrease the chances of rehospitalizations, improve outcome measures, and achieve better survey results.

➤ **Prepare adequately for discharge.** Residents may need to prepare for discharge from the SNF to understand what they will be required to do to maintain their health and recovery at home.

➤ **Provide family education.** Maintaining a resident’s health outside of the facility often extends to a resident’s family or caregivers. Involve everyone who cares for the resident in discharge preparations.

It’s important to recognize that while in recent years Congress has more often than not ignored MedPAC recommendations to freeze or cut long-term care providers’ reimbursement rates, past recommendations were not as broad as those approved in January, making the implementation of these proposals a very real possibility.
MDS professor

Test your knowledge of the MDS and long-term care by answering the following questions.

1. Nursing hours per resident include ________.
   a. total LVN/LPN only
   b. total LVN/LPN + RNs
   c. total RNs only
   d. total RNs + LVN/LPN + CNAs

2. A nursing facility must have an RN on duty for at least ________.
   a. eight hours five days a week
   b. eight hours seven days a week
   c. 16 hours five days a week
   d. 16 hours five days a week and eight hours on weekends

3. Which of the following facilities must employ a qualified full-time social worker?
   a. A 70-bed facility
   b. A 100-bed facility
   c. A 125-bed facility
   d. All of the above

4. The DON position can be held by either an LPN or an RN.
   a. True
   b. False

5. The MDS process and nursing home billing are based on what type of billing system?
   a. Indirect
   b. Retrospective
   c. Prospective
   d. Introspective

6. The MDS coordinator must be an RN.
   a. True
   b. False

7. An RN is the only person who can sign the completion of the MDS.
   a. True
   b. False

8. The DON may serve as a charge nurse only when the facility has a daily average census of ________ or less.
   a. 40
   b. 60
   c. 80
   d. 100

Find the correct answers on p. 12.

Learn how to run a successful SNF

The Comprehensive Guide to Nursing Home Administration, written by Dr. Brian Garavaglia, serves as a blueprint to managing staff, developing a budget, and navigating the ever-changing SNF regulatory environment. Complete with an emphasis on high-focus survey targets such as Medicare reimbursement, quality care, and documentation, this book also contains more than 850 downloadable test questions to ensure SNF administrators are well prepared to improve operational efficiency. This book will help you:

➤ Create a culture of communication and efficiency by clearly defining staff roles and responsibilities
➤ Reduce staff turnover by hiring the most qualified employees and providing effective training
➤ Achieve regulatory compliance by being survey-ready at all times through implementation of appropriate policies and procedures
➤ Gain a thorough understanding of the MDS 3.0, RUG-IV, and SNF reimbursement to maintain your facility’s financial viability

For more information about this product, visit HCPro at www.hcmarketplace.com/prod-10292.
PPS Q&A

Editor’s note: This month’s “PPS Q&A” was modified from the HCPro book Competency Management in Long-Term Care: Skills for Validation and Assessment, by Barbara A. Brunt, MA, MN, RN-BC, NE-BC, and Kelly Smith Papa, RN, MSN. For more information about this book or to order, call customer service at 800/650-6787 or visit www.hcmarketplace.com/prod-7729.

To submit a question for upcoming issues, e-mail Editor Justin Veiga at jveiga@hcpro.com.

Q: We’re in the process of revising our competency assessment program. What should our skills checklists focus on?

A: Skills checklists must clearly identify expectations and should be completed by staff members who know how to use them. Criteria for safe, effective performance must be clearly defined, and everyone participating in the evaluation process must have a common understanding of the criteria and the basis for assigning ratings. Research has shown that making direct observations using precise measurement criteria in checklists, with immediate feedback on performance, is more effective than the traditional evaluation of clinical skills using subjective rating forms. The format for skills checklists may vary, but most contain similar information.

Regardless of how they are used, these skills checklists should:

➤ Be learner-oriented
➤ Focus on behaviors
➤ Be measurable
➤ Use criteria validated by experts
➤ Be specific enough to avoid ambiguity

The steps identified in the checklist should define the critical behaviors needed for effective performance of the skill and do not include every step of the procedure. You can use the “Completed” column to indicate that each step was performed correctly, but note that some checklists use a “Met/Not met” format instead. It is helpful if checklists include an area for comments. Also note that most checklists are used to evaluate one occurrence. In the checklist format just described, the self-assessment can give the evaluator an idea of the individual’s perceived skill level, although that can never take the place of validating competency.

MDS professor answer key

Below are the answers to the MDS professor on p. 11:

1. d. 4. b. 7. a.
2. b. 5. c. 8. b.
3. c. 6. b.

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Complimentary Issue

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