

Nursing Home Improvement and Feedback Tool (NHIFT) [08/15/05]

(2) TOOLUSED

Which tool was used to perform the screening? (Check one)

- Beck Depression Inventory (BDI)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Cornell Scale for Depression in Dementia (CSDD)
- Geriatric Depression Scale (GDS)
- Hamilton Rating Scale for Depression (Ham-D)
- Patient Health Questionnaire-9 (PHQ-9)
- Other

(3) SCREENPOSDEP

Did the resident screen positive for depression?

- No (Skip to next clinical topic)
- Yes

(4) FOLLOWUPDEP

What follow-up was initiated for the resident who screened positive for depression? (Check all that apply)

- Clinical and diagnostic evaluation (beyond initial screen)
- On-going observation with formal re-evaluation in two weeks ("watchful waiting")
- Treatment (e.g., drug or non-drug)
- None
- Unable to determine from chart or medical record

(5) DIAGDEP

Was the resident diagnosed with depression or depressive symptoms?

- No (Skip to next clinical topic)
- Yes

(6) TREATSYMPTOMS

What actions were taken to treat the symptoms? (Check all that apply)

- Group therapy
- Pharmacological intervention (medication)
- Psychotherapeutic counseling (psychotherapy)
- Transfer for inpatient psychiatric care or electroconvulsive therapy (ECT)
- Watchful waiting with clinical management
- None of the above

(7) MANAGESYMPTOMS

What actions were taken to manage the symptoms? (Check all that apply)

- Community connection (e.g., volunteer programs, program to "give back" to community)
- Environmental (e.g., room personalization, accommodations for sensory loss, massage, aromatherapy)
- Multidisciplinary consultation
- Reminiscence groups (e.g., life review)
- Recreation therapy
- Spiritual (e.g., hospice, pastor, rabbi, lay person)
- Watchful waiting with re-evaluation
- None of the above

These questions are based on clinical best practices, not necessarily CMS regulatory requirements.

(8) REEVALEFFECTS

Is there evidence that the resident was re-evaluated within two weeks of the intervention to monitor the effects?

- No
 Yes

SECTION III: Pain

(1) SCREENEDPAIN24

Was the resident screened for pain within 24 hours of admission?

- No *(Skip to next clinical topic)*
 Yes

(2) INDICATEPAIN24

Did the screening within 24 hours of admission indicate the resident had pain?

- No *(Skip to next clinical topic)*
 Yes

(3) PAINASSESS24

Indicate items included in resident pain assessment within 24 hours of admission. *(Check all that apply)*

- Documentation of what improves (relieves) pain (past or present)
- Documentation of what worsens (increases) pain (past or present)
- Effects of medication (past or present) documented
- Effects of pain on activities of daily living, sleep, and mood documented
- Frequency of pain documented
- Intensity of pain documented
- Location of pain documented

(4) POCRAIN48

Was a plan of care put into place to address pain within 48 hours of admission?

- No *(Skip to [6] PAINMED24)*
 Yes

(5) NONDRUG48

Indicate non-drug therapies included in the resident's pain plan of care within 48 hours of admission.

(Check all that apply)

- Alternative medicine (e.g., aromatherapy, Reiki)
- Cutaneous stimulation/relaxation (e.g., deep breathing, massage therapy, TENS)
- Psycho/Social (e.g., counseling, distraction)
- Therapy-related (e.g., heat treatment, cold treatment)
- Unspecified non-drug therapies
- None

(6) PAINMED24

Indicate orders for pain medication within 24 hours of identification of resident's pain. (Check one of the following)

- Regularly scheduled pain medication and PRN medication for breakthrough pain
- Regularly scheduled pain medication only
- PRN medication for breakthrough pain only
- No pain medication prescribed

(7) DIAGCAUSEPAIN

Did the resident have a diagnosis for the underlying cause(s) of pain within 30 calendar days of admission?

- No
- Yes

SECTION IV: Physical Restraints

(1) PR48

Was the resident physically restrained any time within 48 hours of admission?

- No *(Skip to next clinical topic)*
- Yes

(2) RSNPR

Is there a physician's order and reason why a physical restraint was ordered?

- No
- Yes

(3) TYPEPR48

What type of physical restraint was applied within 48 hours of admission? (Check all that apply)

- Chair that prevents rising
- Limb (e.g., wrist, leg)
- Side rails
- Vest
- Waist
- Other

(4) RESTRICTDEVICE

Was there an assessment within 48 hours of admission to determine if the physical restraint used is the least restrictive device to treat the resident's medical symptoms?

- No
- Yes

(5) REEVALPR

In addition to the regular care-planning meeting, does the resident's record document a plan to regularly re-evaluate this resident to reduce or eliminate the physical restraint?

- No
- Yes

SECTION V: Pressure Ulcers

(1) SKINASSESSMENT24

Did the resident receive a skin assessment within 24 hours of admission?

- No (Skip to [14] HXPU)
- Yes

(2) STAGEPUADM

Indicate the highest staged pressure ulcer present at admission. (Check one)

- No pressure ulcers present at admission (Skip to [14] HXPU)
- Stage I
- Stage II
- Stage III
- Stage IV
- Unable to stage (e.g., due to presence of eschar)

(3) PUEVAL24

Was the resident's highest staged pressure ulcer evaluated within 24 hours of admission?

- No (Skip to question [14] HXPU)
- Yes

(4-13)

Did the evaluation of the highest staged pressure ulcer include documentation of the following?

- (4) PUEVALSTAGING
- (5) PUEVALSIZE
- (6) PUEVALLOCATION
- (7) PUEVALEPITHELIAL
- (8) PUEVALEXUDATES
- (9) PUEVALGRANULATION
- (10) PUEVALNECROTIC
- (11) PUEVALSINUSTRACTS
- (12) PUEVALUNDERMINING
- (13) PUEVALTUNNELING

- No Yes
- No Yes
- No Yes
- No Yes N/A
- No Yes N/A
- No Yes N/A
- No Yes N/A
- No Yes N/A
- No Yes N/A
- No Yes N/A
- No Yes N/A

(14) HXPU

Does the resident have a reported history of pressure ulcers?

(History can be established from resident or family reports, or from medical record)

- No
- Yes
- Not assessed

(15) RISKPUTOOLUSED

Was the resident assessed for risk of developing pressure ulcers using a standardized risk assessment tool such as the Braden, Norton, or Norton Plus scale within 24 hours of admission?

- No
- Yes (Skip to [21] SCREENATRISK)

(16-20)

If the Braden, Norton, or Norton Plus Scales were not used within 24 hours of admission, was there a pressure ulcer risk assessment that included the following elements? (Check all that apply)

- (16) RISKINCONTINENCE** No Yes Documentation of bladder/bowel incontinence and/or moisture
- (17) RISKCOGNITIVE** No Yes Documentation of cognitive impairment
- (18) RISKMOBILITY** No Yes Documentation of impaired bed/chair mobility
- (19) RISKFUNCSTATUS** No Yes Documentation of impaired functional status
- (20) RISKNUTRISTATUS** No Yes Documentation of impaired nutritional status

(21) SCREENATRISK

Based on the screening criteria, is the resident at risk for pressure ulcers?

- No (Stop abstraction)
- Yes

(22) SKININSPECTEDDAILY

If the resident is at risk for pressure ulcers, was his/her skin inspected daily to detect new pressure ulcers? (Inspection should include bony prominences and heels) (May be performed by nurses or nursing assistants)

- No
- Yes
- Unable to determine

(23) POCRISKFACTORS

If the resident is at risk for pressure ulcers, does the plan of care incorporate interventions that address each of the resident's specific risk factors?

- No
- Yes

(24) CHAIRSUPPORT

Using visual inspection, determine which chair support surfaces are being used by the at-risk resident. (You must observe the resident's chair support surface) (Check all that apply)

- Gel cushion
- High-density foam at least four inches thick
- Properly inflated static air or fluid cushion
- Other specially-designed cushion
- None of the above

(25) BEDSUPPORT

Using visual inspection, determine which bed support surfaces are being used by the at-risk resident. (You must observe the resident's bed) (Check all that apply)

- Air fluidized
- Dynamic air (air overlay)
- High-density foam overlay at least four inches thick
- High-density foam mattress
- Low air loss
- Properly inflated static air or fluid mattress
- None of the above

INSTRUCTIONS: Answer the following questions only if the resident had a pressure ulcer(s) on admission. Otherwise, stop abstraction.

(26) WEEKLYASSESSMENT

If the resident had a pressure ulcer(s) on admission, is there documentation of a weekly wound assessment for each pressure ulcer?

- No
- Yes

(27) PROFSTANDARDS24

If the resident had a pressure ulcer(s) on admission, was a treatment plan consistent with current professional standards initiated for each pressure ulcer within 24 hours of admission?

- No
- Yes

(28) TPIMPLEMENTED

If the resident had a pressure ulcer(s) on admission, is there documentation that the treatment plan for the pressure ulcer(s) was consistently implemented as written?

- No
- Yes

(29) IMPROVE4WEEKS

If the resident had a pressure ulcer(s) on admission, is there evidence of improvement in the wound(s) by or before the end of the fourth week since admission?

- No
- Yes (Stop abstraction)
- Unable to determine from medical record

(30) NOIMPROVETXPLAN

If there was no improvement in the wound by the end of the fourth week since admission, was the treatment plan modified or is there documentation indicating why the current treatment plan should continue?

- No
- Yes
- Unable to determine from medical record