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3 Title: Signage Balancing Patient Safety, Quality of Care, and Patient Dignity
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5 Introduced by: David Whalen, MD, for the Kent County Delegation
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7 Original Author: Jayne E. Courts, MD, FACP
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9 Referred To:
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11 House Action:
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14 Whereas, patients who reside in a skilled nursing facility (SNF), either for sub-acute
15 rehabilitation (SAR) or long-term care (LTC), often have safety or care needs that need to be
16 addressed by the health care team at the SNF, and
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18 Whereas, included in these patient care needs are often simple, but important, care plan
19 concerns such as the number needed for assist due to the fall risk, the need to follow a dysphagia
20 diet (with thickened liquids), or the need to follow a fluid restriction, and
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22 Whereas, SNF staff are trained to respond to call lights as quickly as possible, including
23 responding to call lights of any residents who require assistance, even if the patient has not been
24 assigned to that staff member, and
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26 Whereas, a staff member may provide assistance to a patient with whom he/she is not
27 familiar, including lack of familiarity with the care plan, and
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29 Whereas, in the inpatient setting or in the acute rehabilitation setting, patients at risk for
30 falls often wear wristbands clearly indicating this potential risk in an effort to reduce falls and the
31 possible adverse consequences for the patient, and
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33 Whereas, this readily visible reminder is seen as a patient safety and quality of care measure
34 that benefits the patient and helps to reduce the number of fall "never events," and
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36 Whereas, the regulatory environment in the SNF setting is determined by the Centers for
37 Medicare and Medicaid Services (CMS), and
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39 Whereas, CMS's interpretive guidelines require that an environment must be maintained in
40 which there are no signs posted in residents' rooms or in staff work areas able to be seen by other
41 residents and/or visitors that include confidential clinical or personal information (though signage
42 in non-visible, non-readily seen locations such as the inside of a cupboard door in the resident's
43 room is permissible), and
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45 Whereas, any publicly visible identification of residents with a fall risk such as a wristband is
46 deemed to be a violation of patient dignity requirements, rather than as a potential method of
47 ensuring the patient's safety and provision of quality of care, and
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49 Whereas, this requirement to ensure information is not viewable by the public doesn't even
50 allow a colored dot on the room number by the door to alert SNF staff members to patient care
51 needs such as a dysphagia diet, fluid restrictions, or other patient safety and quality concerns, and
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53 Whereas, non-adherence to this regulatory approach, believed to preserve the dignity of
54 the patient, will result in a citation which may include plan of correction requirements, education of
55 the staff, and monetary infractions, including but not limited to denial of payment until the CMS 7
56 surveyors have resurveyed the SNF and have determined that the regulatory guidelines have been
57 met through the plan of correction, and
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59 Whereas, CMS citations may result in a reduction in the SNF's five-star rating which may
60 affect reimbursement rates and the SNF's reputation and possible referral rates until the five-star
61 rating has improved, and
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63 Whereas, identification of patients at risk for falls in the inpatient setting or the acute
64 rehabilitation setting is not considered to be an infringement on the patient's dignity, but is viewed
65 instead as a safety concern for the protection of the patient; therefore be it
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67 RESOLVED: That MSMS work with appropriate stakeholders to review the rationale for the
68 Centers for Medicare and Medicaid Services' patient dignity regulations applicable to long-term
69 care facilities and determine acceptable indicators or markers with better visibility to indicate
70 patients with an increased fall risk or other health care risk concerns; and be it further
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72 RESOLVED: That MSMS work with the appropriate stakeholders to develop and advocate
73 for recommended changes to the Centers for Medicare and Medicaid Services' patient dignity
74 regulations applicable to long-term care facilities so that discrete, but readily visible, indicators or
75 markers of a patient's health care risk concerns may be used for the benefit and safety of patients
76 without triggering a citation; and be it further
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78 RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask
79 our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to review the
80 rationale for CMS's patient dignity regulations applicable to long-term care facilities and determine
81 acceptable indicators or markers with better visibility to indicate patients with an increased fall risk
82 or other health care risk concerns; and be it further
83

84 RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask
85 our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to change the patient
86 dignity regulations applicable to long-term care facilities so that discrete, but readily visible,
87 indicators or markers of a patient's health care risk concerns may be used for the benefit and safety
88 of patients without triggering a citation.
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91 WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy -
92 \$25,000+

Relevant MSMS Policy:

None

Relevant AMA Policy:**Residential Facility Regulations H-280.984**

Our AMA advocates for patients in long-term care, group home and other residential settings and will: (1) strive to see that enhanced quality of care results from any new proposed state or federal regulations; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients; (3) urge state regulatory bodies and HHS to seek consultation and advice from the AMA and other professional medical societies when developing rules and regulations that affect medical care; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term, group home or other residential setting care, and provide testimony and information about appropriate medical management of patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal and state health agencies as they formulate health and safety standards.