



# Mismatched Needs and Services Can Lead to Harm A Systems REThinking Approach

*An Aging Services White Paper*

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# Mismatched Needs and Services Can Lead to Harm

## A Systems RETHinking Approach

By Victor Lane Rose, MBA, NHA, FCPP, CPASRM, Director, Aging Services  
Josi Wergin, CPHRM, CPASRM, ELS, Risk Management Analyst

What do the following situations—nearly all of which are based on actual events or lawsuits or on questions from ECRI Institute members—have in common?

*A continuing care retirement community (CCRC) determines that an independent-living resident requires transfer to assisted living. The resident wants to stay in independent living and retain private care, but her care needs exceed that which state law allows to be provided in independent living.*

*As a community adopts person-centered care and promotes aging in place, it gains a growing population of independent-living residents who need assistance with transportation. The provider considers booking rideshare services for residents and patients who do not have a ridesharing account to get to personal and medical appointments.*

*The mother of a board member needs care. Staff determine that she requires a skilled nursing level of care, but the board member and the prospective resident insist that the resident live in assisted living.*

*While discussing the amenities in independent living, the sales manager tells prospective residents and families, “In case of a medical emergency, you can get someone to assess the situation and call for more help just by pulling a cord.”*

*In accordance with a preferred provider agreement, the hospital sends a referral for post-acute care. Although the person could benefit from rehabilitation, the prospective patient has multiple comorbidities as well—including a recent history of suicidal ideation. Occupancy in the short-stay unit has been low for several weeks.*

*A CCRC in a region with cold winters admits an independent-living resident with a history of memory problems and a tendency to wander. The doors of the building lock automatically from the outside.*

*A CCRC has a guideline that residents who cannot carry their own bags cannot participate in shopping outings alone; companions hired by residents may accompany the resident on the CCRC’s bus. An independent-living resident asks the CCRC to provide a companion to accompany her while she completes errands such as shopping—without additional charge.*

Although these situations raise a variety of risk management concerns, from lawsuits to resident or family dissatisfaction to regulatory or licensure problems, the common theme is scope of service.

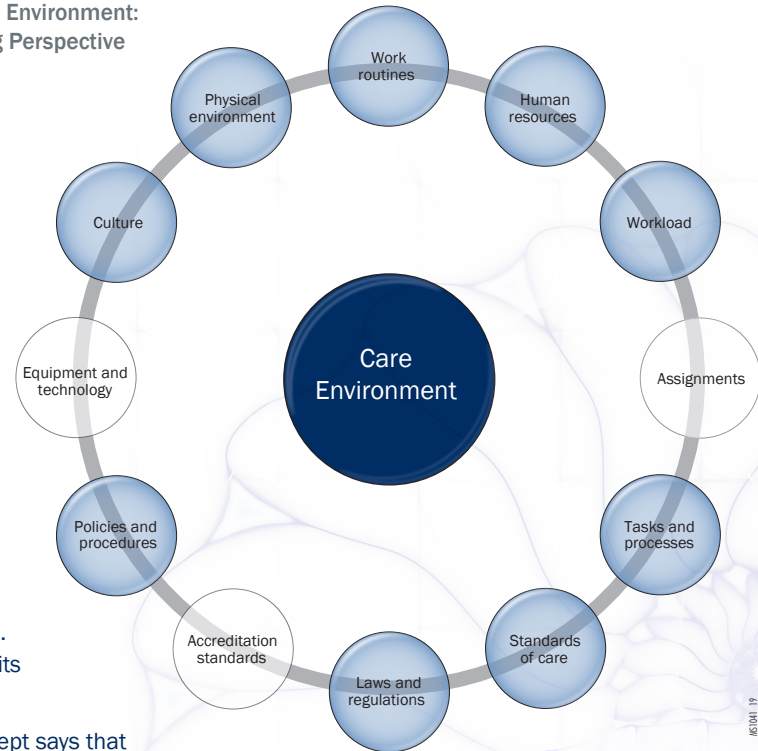
Processes for preadmission, admission, discharge, and transition in care are at the very heart of every provider organization. These daily processes result in decisions that can either align with the scope of service or lead to mismatches between a person's needs and the scope of service within a service line. Risks associated with such mismatches have the potential for great harm to all stakeholders and can even be deadly. Organizational processes that lead to mismatches are potential root causes that can manifest as many different types of problems throughout any care and service delivery system.

Having a well-defined scope of service for each service line offers benefits to aging services organizations:

- It helps organizations ensure that they are able to meet residents' or patients' needs.
- It provides a framework for making decisions about admissions, transfers, and discharges of individual residents.
- It helps staff recognize that every admission represents a decision, as does allowing a resident to remain in a given service line.
- It supports decision makers when they determine that the service line cannot meet the individual resident's needs.
- It promotes realistic expectations and a shared understanding among stakeholders.
- It serves as a guide for staff when developing marketing materials, brochures, and other literature used to convey care and services bundled in a particular service line.
- It facilitates evaluation and implementation of management decisions, such as expansion of services, entering into contracts for additional services, and other issues.

Effective preadmission, admission, discharge, and care transition processes, as well as other processes that inform and support the scopes of service within the organization, have many components, and they are interconnected with other facets of the care environment (see the shaded circles in [Figure 1. Scope of Service and the Care Environment: A Systems Thinking Perspective](#)). It takes the combined efforts of many stakeholders and disciplines as well as the person served and, when involved, the family.

Figure 1. Scope of Service and the Care Environment:  
A Systems Thinking Perspective



## What Is Systems Thinking?

The systemic approach to management, also called a systems thinking approach, focuses on two fundamental concepts.

The first concept is that “a whole is more than the sum of its parts.” The interactions between the things that make up a system are just as important as the individual parts in fulfilling an organization’s mission and purpose. It also suggests that the whole possesses characteristics that none of the parts individually possess. It has everything to do with organization design: individual positions to teams to departments, the processes that connect them, and the alignment of systems inside and outside the organization. This means that all parts are important to fulfilling a system’s purpose. It also means that removed from the system, a part loses its purpose and the system behaves differently.

The second concept is the development ethic. This concept says that every individual in the system should be encouraged to develop and use his or her fullest positive potential for the benefit of the person and the organization. “The inputs required to do this are a reasonable salary, access to required and desired learning, a managerial system that treats them fairly and encourages development, and a work environment that does not hamper their efforts.” (Roth)

Organizations that incorporate a systems thinking approach share four key characteristics:

1. True participation. All employees affected by a decision have some level of input into that decision.
2. Full integration. This characteristic recognizes the reality of the whole; therefore, activities are coordinated on all levels and between all levels.
3. Ongoing learning. The organization’s activities and processes support and reward continual learning for all employees, which also contributes to the ongoing learning of the system.
4. Ongoing feedback and continuous improvement. The organization has processes that allow it to adapt fluidly to changing internal and external environments.

By using a systems thinking approach, leaders can better understand behaviors of the organization and increase their effectiveness in achieving the organization’s goals and fulfilling its purpose. This includes recognizing older adults as stakeholders. By thinking in terms of parts, processes, and alignment, organizations can create shift-by-shift care environments that promote safety and quality of life for all involved, including the organization itself, and fluidly adapt and improve.

**Source:** Roth W. A systemic approach to improving corporate performance. *Bus Manag Dyn* 2014 Oct;4(4):27–31. [http://bmdynamics.com/issue\\_pdf/bmd110504-%2027-31.pdf](http://bmdynamics.com/issue_pdf/bmd110504-%2027-31.pdf)

## Scope of Service: Concepts and Analysis

Scope of service helps to draw a picture of the many types of care and services a delivery system provides to care for and support the ongoing health and needs of the person served. It might help to visualize scopes of service as the dotted-line ovals represented in Figure 2. **Drawing a Picture: Scopes of Service across the Care Continuum.** Each oval represents the bundled care and services that a provider organization puts together to create a service line. This works for stand-alone provider organizations throughout the aging services continuum, as well as CCRCs and life plan communities.

When analyzing scope of service, consider the continuums of care within and across community health systems, provider health systems, and individual provider organizations. Having a degree of overlap can help provide flexibility and person-centered care (see Figure 3. **The Ideal: Appropriate Overlap in Scopes of Service between Service Lines**), as long as the service line is designed to meet care-critical needs of the person served within that service line.

Mapping out service lines and considering the degree of overlap between scopes of service can also help to identify potential gaps between service lines (see Figure 4. **Reality: Gaps in Scopes of Service between Service Lines**), where those served might fall through.

Figure 2. Drawing a Picture: Scopes of Service across the Care Continuum

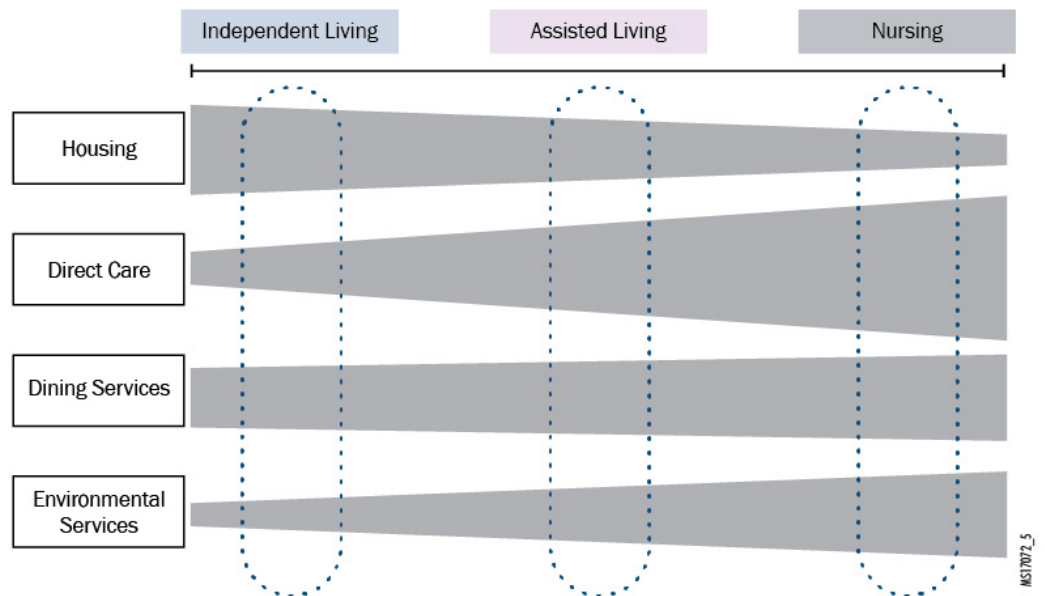


Figure 3. The Ideal: Appropriate Overlap in Scopes of Service between Service Lines

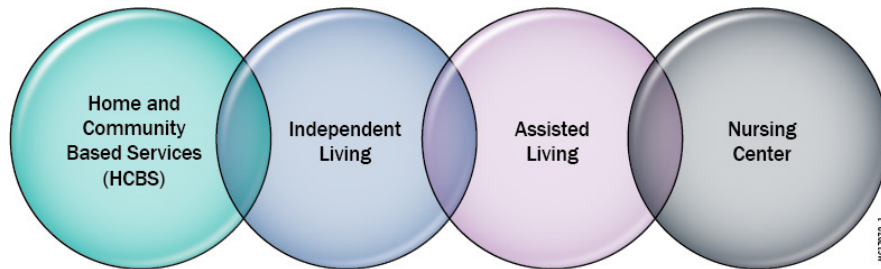


Figure 4. Reality: Gaps in Scopes of Service between Service Lines

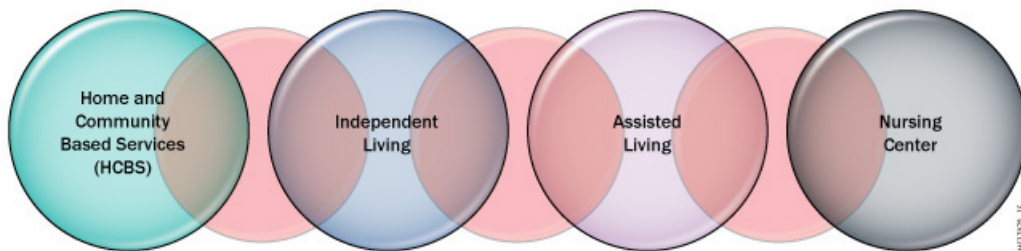
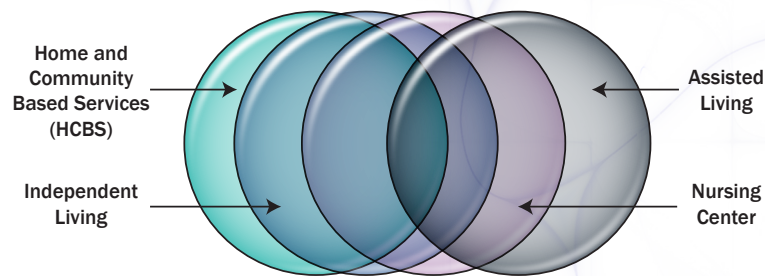


Figure 5. Reality: Compression of Scopes of Service between Service Lines

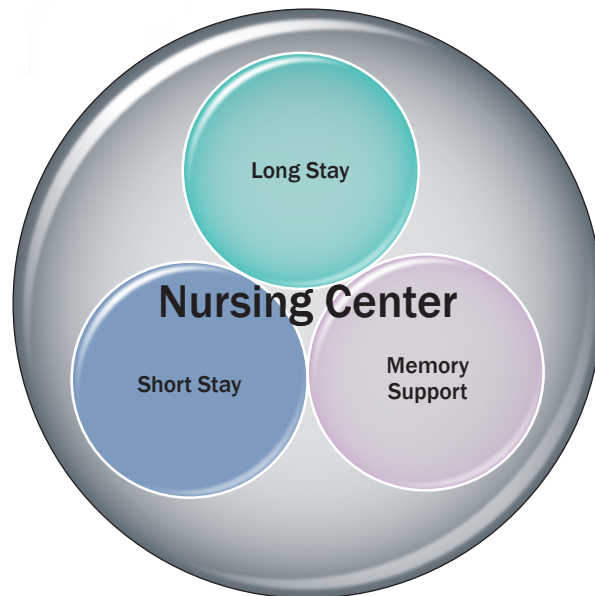


Conversely, a lack of design or definition can compress scopes of service and service lines so much that it is hard to distinguish where one service line starts and the other stops (see Figure 5. Reality: Compression of Scopes of Service between Service Lines). In these instances, the potential for harm can abound because it is difficult to match a person’s served needs and the care and services available or even permitted within a service line.

Notably, a single organization can experience both gaps and compression simultaneously. For example, there may generally be compression between independent living and assisted living but a gap between assisted living and skilled nursing. Or there may be gaps regarding specific care needs (e.g., wound care) and compression regarding others (e.g., memory care).

Additionally, within service lines, there are often multiple levels of care. In a skilled nursing service line, several levels of care might exist, such as long-stay care, short-stay care, and memory support (see [Figure 6. Multiple Levels of Care within a Service Line](#)). While levels of care may share core care and services common to skilled nursing delivery systems, each typically offers care and services that are unique to the needs of persons served in that level of care and are necessary to create the therapeutic milieu that best matches those needs. The same is true in other service lines throughout an aging services continuum, such as assisted living (e.g., traditional assisted living, assisted living memory support) and home and community based services (e.g., home care, home health, hospice, Program of All-Inclusive Care for the Elderly [PACE]).

Figure 6. Multiple Levels of Care within a Service Line

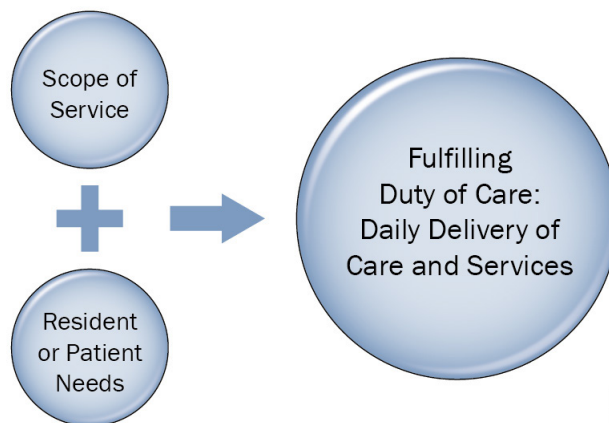


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## Risks of Poorly Designed or Inconsistent Scopes of Service

Defining and understanding scope of service helps provider organizations and persons served in many ways, acting as a template for daily operational decision-making about admissions, discharges, and transitions in care. Going through the process of writing scope-of-service documents forces organizations to articulate the specific care and services provided within that service line. Developing the scope of service also brings in an element of intentional design, reducing ambiguity for all stakeholders: those providing care and services as well as those receiving them. This helps in other healthcare risk mitigation and quality improvement practices, such as setting realistic expectations, because it gives those charged with explaining the capabilities of a delivery system the information they need to be successful. When processes are in place to harmonize the needs of persons served with the capabilities of the delivery system, a greater likelihood exists to fulfill duty-of-care obligations (see [Figure 7. Fulfilling Duty of Care by Matching Scope of Service to Needs](#)).

Figure 7. Fulfilling Duty of Care by Matching Scope of Service to Needs



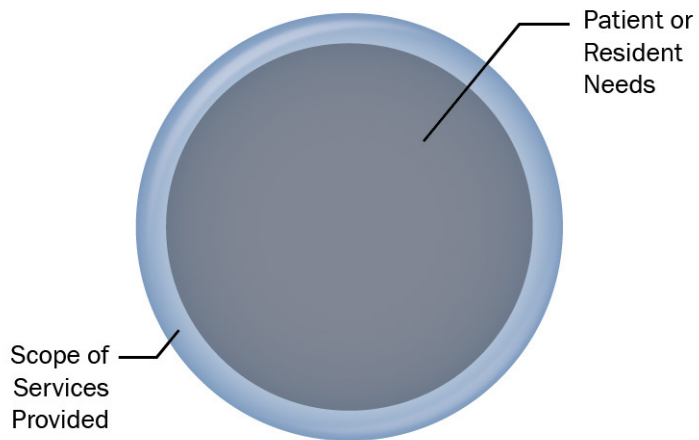
When the needs of the person served and the capabilities of the service line and level of care do not align, risk and the potential for harm may emerge. In a desirable situation, a resident's needs neatly fall within the scope of service within a service line (see [Figure 8. The Perfect Match of Needs and Services Provided](#)). In such situations, the care environment can respond to the needs of persons served 24 hours a day, 365 days a year.

Risk develops when the organization admits a person whose needs fall outside the capabilities of a delivery system, because those needs cannot be met consistently (see

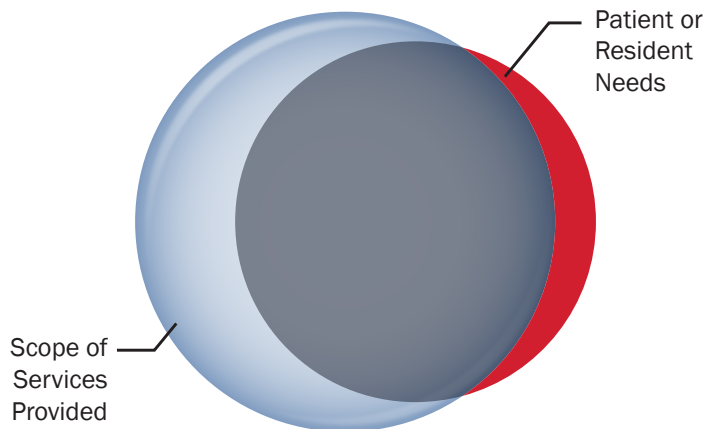


**Figure 9. Mismatches at the Time of Admission, Creating Risk.** This can be caused by many factors: the delivery system was never designed to meet needs at that acuity level, staffing levels do not safely or consistently allow those needs to be met, or care-critical competencies do not exist to the degree necessary to deliver those services (e.g., intravenous medications, management of peripherally inserted central catheters). Thus, when a person is admitted to a care setting where these mismatches occur, an area of risk related to unmet needs can exist from the start. See “CCRC Responsible for Ensuring Appropriate Placement, Services in Independent Living, Plaintiff Argues,” which illustrates a case that highlights these concerns.

**Figure 8. The Perfect Match of Needs and Services Provided**



**Figure 9. Mismatches at the Time of Admission, Creating Risk**  
At the time of admission or readmission, an individual's needs that are outside the scope of services for the care setting can go unmet.



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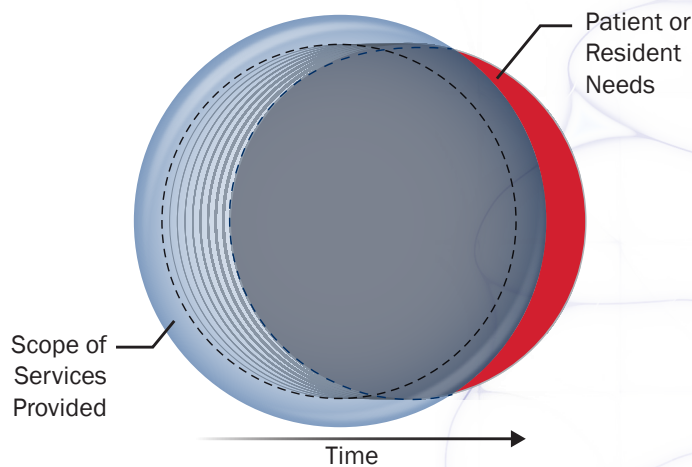
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However, care delivery systems must also be aware of the ever-changing needs of persons served within the scope of service. Because a person's needs tend to change over time, risk can develop as those needs drift beyond what the scope of service is capable of meeting (see [Figure 10. Mismatches That Arise Over Time, Creating Risk](#)). Thus, delivery systems determine the needs of the person served prior to admission and over time, during the person's residency in the service line.

**Figure 10. Mismatches That Arise Over Time, Creating Risk**

As an individual's needs change over time, they can slide out of the scope of services for the care setting, creating risk when needs go unmet



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Furthermore, the provider organization must have processes in place to recognize risky situations, take appropriate action when they are identified, and then either add to the services provided within the service line based on the scope of service or begin a care transition process if the needs fall outside of the capabilities of the scope of service.

Scopes of service do also change somewhat, expanding and contracting with different day-to-day operating situations and organizational processes (see [Figure 11. Contraction of Scope of Service](#) and [Figure 12. Expansion of Scope of Service](#)). A small degree of expansion or contraction sometimes supports safety or quality of care and services and can reflect important management and operational considerations. For example, when occupancy levels are high, organizational decision-making might become tighter regarding the needs that can be met by a service line or level of care.

Other times, expansion or contraction creates risk. To continue the example, when occupancy levels are low, the temptation to fill occupancy may lead the organization to admit residents whose needs exceed what the scope of service was intended to serve.

## CCRC Responsible for Ensuring Appropriate Placement, Services in Independent Living, Plaintiff Argues

A lawsuit filed by the son of an independent-living resident who died after being locked out of her building on a cold night illustrates the importance of intentionally designing scopes of service, defining admission and discharge criteria, matching services provided to residents' needs, and conducting ongoing assessments.

Before her move to the continuing care retirement community (CCRC), the resident's neighbors told her son that she was acting strangely and wandering at night, according to reports. The son said he told the CCRC about her memory problems and wandering; however, court filings indicated that the CCRC was unaware of the resident's memory issues. After the resident moved in, the CCRC called the son, on multiple occasions, to notify him that she had been wandering.

The son took the resident to see a doctor who practiced in an office on the CCRC's campus. The doctor diagnosed Lewy body dementia and told the son she would require more care someday. Although the son assumed that the CCRC would be told this information, the physician's practice leased the office and was independent of the CCRC. Although the resident could have easily afforded the cost of assisted living, neither the son nor the CCRC raised the possibility of moving the resident.

On a cold night in March, the resident left the building at 2:15 a.m. without her key card. She was wearing pajamas, and her feet were bare. Security footage showed the resident pounding and pulling on the door. She also repeatedly touched the keypad that let residents call security, but it was unclear whether she entered the correct four-digit code.

The resident was found lying face-down at about 7:00 a.m. Her skin was turning blue, and she had icicles on her hands and feet. She died the next week.

The resident's son sued the CCRC and its security company. According to him, the CCRC said it would assess the resident but did not do so. In a Philadelphia Inquirer article that examined the question of who is responsible, the family or the CCRC, for raising level-of-care concerns in independent living, the plaintiff's lawyer said that the CCRC should have put the resident "in the right place to get the right care so she'd still be alive today." The lawsuit was pending as of August 2018.

**Source:** Burling S. His elderly mother wandered out into the cold and died. Whose fault was it? Phila Inq 2018 Feb 9 [cited 2018 Jul 13]. <http://www.philly.com/philly/health/health-news/dementia-and-wandering-can-be-deadly-alzheimers-lewy-body-20180208.html>

Having written scopes of service can help to control expansions and contractions by removing ambiguity and providing a framework to make decisions more routine. In addition, it creates organizational awareness vital to identifying when perceptions about capabilities contribute to risky and potentially harmful mismatches between scope of service and the needs of the person served.

Figure 11. Contraction of Scope of Service

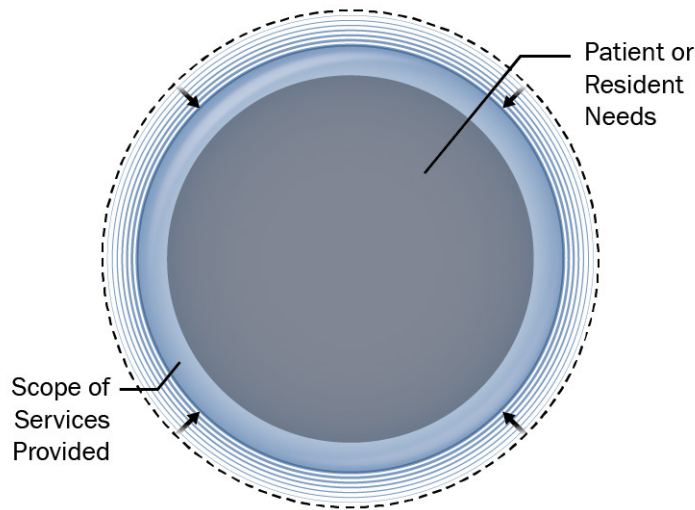
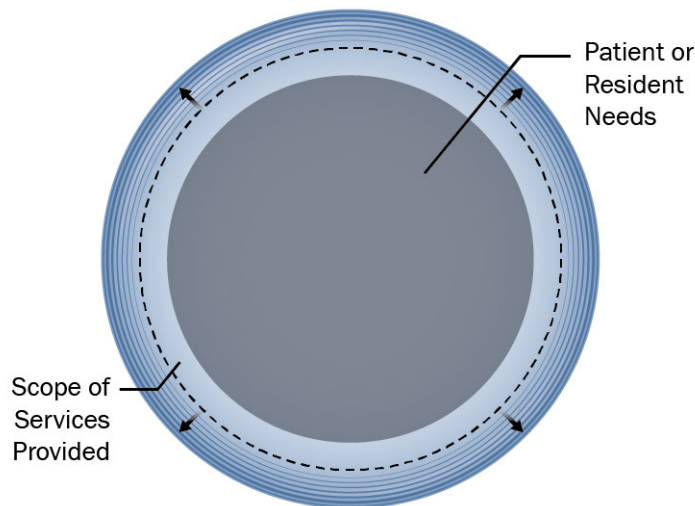


Figure 12. Expansion of Scope of Service



Scope of service must also take into account the 24-hour care cycle, which includes swings in resident needs as well as changes in staffing and scheduling, because they can contribute to contraction and expansion of scope-of-service capabilities. For example, if a person served experiences “unpredictable” care needs or care needs throughout a 24-hour care cycle, the scope of service needs to provide care and services that consistently meet those needs when they occur. Otherwise, periods of risk emerge when the services are unavailable. If a person needs continence care throughout the 24-hour cycle for example, but has home care support only at certain times during the day, episodic risky situations can occur that can lead to falls, pressure injuries, or other negative outcomes.

## Establishing the Scope of Service in Each Service Line

Aging services organizations need to define their scope of service for each service line. Some elements of a scope of service for a particular service line are outlined in state licensure requirements or requirements of participation in federal healthcare programs. Running afoul of these regulations can risk termination of licensure or participation in federal healthcare programs. But these regulations can also support communities facing challenges from residents. “CCRC Decision to Transfer Independent-Living Resident Not Discriminatory, Court Rules” illustrates how state law helped protect a CCRC from a lawsuit alleging disability discrimination.

An essential tool in defining, maintaining, and applying scope of service is the scope-of-service document. This document describes the rationale for having a scope of service, including underlying regulations, and the services and general staffing provided.

The prevalence of scope-of-service documents varies among healthcare and aging services settings. For example, acute care hospitals and home health agencies that participate in Centers for Medicare and Medicaid Services programs are required to develop and maintain scope-of-service documents. Licensing regulations may require a licensed provider organization to develop and maintain a scope of service, sometimes referred to as a “description of services.” Scope-of-service requirements can exist in either federal or state regulations, depending on the aging services sector or service line.

Aging services organizations should ensure familiarity with applicable regulations and guidance addressing scope of service, including those addressing supporting documentation, for all current and proposed service lines. For example, Pennsylvania law requires personal care homes to have a “current written description of services and activities that the home provides,” including the scope and a description of services, admission and discharge criteria, and services the personal care home will coordinate but does not itself provide (55 Pa. Code § 2600.223(a)). A regulatory compliance guide

## CCRC Decision to Transfer Independent-Living Resident Not Discriminatory, Court Rules

A decision by a continuing care retirement community (CCRC) to transfer a resident to a higher level of care did not violate the Americans with Disabilities Act (ADA) or the Fair Housing Amendments Act (FHAA), a federal district court in California has ruled. The resident had been living in an independent-living apartment for about 13 years when she was hospitalized. The CCRC determined that she needed to be transferred to assisted living on her return.

The resident objected. She returned to her apartment and retained private care for 16 hours a day to assist with hygiene, dressing, and grooming. The CCRC notified the resident that her care needs exceeded that which California law permitted to be provided in independent living and notified the state's Department of Social Services (DSS). DSS directed the CCRC to obtain an updated medical assessment of the resident and warned the CCRC that under state law, the CCRC could not delegate provision of the additional services to another party or person. It also informed the CCRC that if it maintained the resident in independent living, it risked citation for failure to provide basic services to the resident.

The resident sued the CCRC, alleging violations of federal antidiscrimination laws. The resident's personal physician and the court-appointed physician opined that she would likely suffer physically and mentally from a transfer to a skilled nursing setting.

The court found that the CCRC's policy of transferring residents to higher levels of care when necessary did not constitute disability discrimination because it was not applied less favorably to people with disabilities as a group. Rather, the transfer policy complied with state regulations concerning the type of care that CCRCs may legally provide in certain settings and upheld the CCRC's continuum-of-care model.

In her lawsuit, the resident also claimed that the CCRC failed to accommodate her disabilities. The court found that the resident required a degree of care that the CCRC could not legally provide in independent living and could not delegate to privately paid assistants. Further, ADA did not require the CCRC to provide accommodations that would fundamentally alter the nature of its business, the court opined. The court granted the defendants' motion for summary judgment. (*Herriot v. Channing House*, 2009 U.S. Dist. LEXIS 6617 [N.D. Cal. Jan. 29, 2009].)

describes the requisite components in more detail, outlines inspection procedures, and discusses the rationale for and benefits of the requirement. For example, the compliance guide states, in part (Pennsylvania Department of Public Welfare):

*Compliance with this regulation is critical to ensuring that homes serve only those residents whose needs can be met in the home. Homes must be very careful about admitting residents who have dangerous behaviors, who need extensive medical care, or who have personal care/supervision needs that require additional staffing.*

The compliance guide also notes that by reducing the risk of admitting residents whose needs cannot be met, the description of services protects both prospective residents and personal care homes and reduces disputes over denials of admission and discharges (Pennsylvania Department of Public Welfare).

Once developed, scope-of-service documents can serve as internal organizational guidelines for developing other key operational documents like marketing materials, preadmission policies and guidelines, admission appropriateness criteria, discharge policies and guidelines, and residency agreements.

Two vital documents informed by the scope of service are residency agreements and disclosure statements. For example, “nearly all states” require assisted-living and residential care providers to have a residency agreement and outline what information to include in it, and some also require providers to have a disclosure statement, according to a compendium of assisted-living and residential care regulations from the U.S. Department of Health and Human Services’ Office of the Assistant Secretary for Planning and Evaluation. These two documents often include some similar information but serve different purposes. The residency agreement is a contract between the resident and the provider, and it is signed by both parties. The disclosure document, when present, gives prospective residents and families information to help them compare settings and decide whether the setting in question will meet their needs. (ASPE)

Because the scope of service directly informs the residency agreement, which is a contract, scope-of-service disputes can ultimately become contractual issues. The residency agreement and the disclosure statement, if present, also play a role in setting realistic expectations for prospective residents and family members. These and related documents can facilitate preadmission and ongoing discussions of limitations on services available in the setting, the rationale behind these limitations, processes for determining whether the resident continues to meet criteria for remaining in the setting, steps that will be taken if the resident no longer meets those criteria, and services available in other settings.

Scope-of-service documents also help a provider organization to organize the many services provided in a service line and levels of care. In presenting core strategies for transitioning the healthcare system to a value-based system, the authors of a *Harvard Business Review* article write, “At the core of the value transformation is changing the way clinicians are organized to deliver care. The first principle in structuring any organization or business is to organize around the customer and the need.” They propose restructuring healthcare from silos of particular services and specialties to integrated practice units, which organize care around specific conditions (e.g., diabetes care that includes care for kidney and eye problems). (Porter and Lee)

Although the article addresses the restructuring of the healthcare industry as a whole, aging services organizations can consider integrating appropriate services for common patient and resident needs. Such integration can help to reduce fragmentation of the care and services delivered to persons served, which in turn helps to create and maintain care environments that act to inhibit incidents and adverse events. The process of writing scope-of-service documents brings a systems thinking approach into the intentional design of care and service delivery systems.

No matter the healthcare sector or setting throughout the care continuum, scope-of-service documents help a provider organization to define and design its delivery systems. For example, Joint Commission standards for nursing care centers and home care characterize scope of service as key to providing services in a way that optimizes quality and safety—and a central responsibility for leaders. The overview for the “Provision of Care, Treatment, and Services” (PC) chapter states that the standards in the chapter “center around the integrated and cyclical process that allows care to be delivered according to patient or resident needs and the organization’s scope of services.” Joint Commission also requires organizations to describe, in writing, the scope and nature of services provided pursuant to a contractual arrangement (leadership standard LD.04.03.09). An element of performance for the Joint Commission standard holding governance accountable for quality and safety (LD.01.03.01) requires governance to approve the written scope of service. An element of performance for the nursing care centers standard requiring medical directors to oversee care and services (LD.01.06.01) calls on medical directors to advise governance, administrators, and others regarding “the degree to which the organization’s scope of service, its medical equipment, and its professional and support staff meet patients’ and residents’ needs.” (Joint Commission)



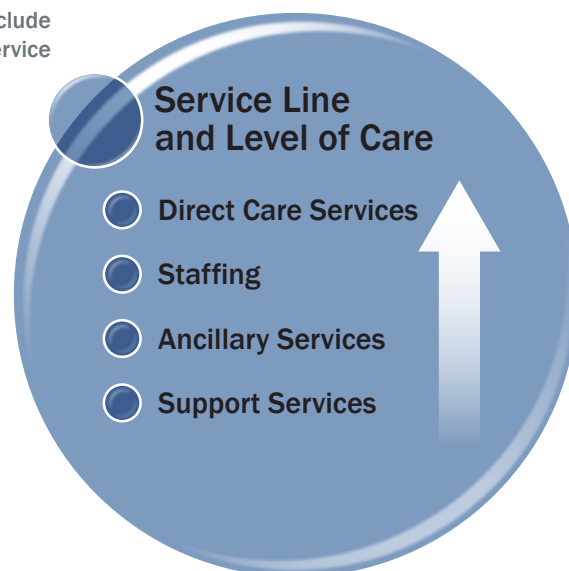
## Designing Scope-of-Service Documents

When designing scope-of-service documents, there are many issues to consider. The document should be detailed enough to provide clarity for use in decision-making in regard to admissions, discharges, and the need to add services to meet resident needs and mitigate risks where permissible.

Many external and internal factors influence the scope of service provided in each service line. These include federal, state, and local laws; licensing agency regulations; standards of care; acuity levels; industry forces; and decisions made by the provider organization. It is also important to remember that a scope of service includes care and services provided directly by a provider organization as well as those that are provided by others, either contractually with the provider organization or as direct contractual relationships with the resident or other providers (e.g., private-duty caregivers).

In fact, the care and services described in a scope-of-service document are not necessarily limited to only those provided by the provider organization. Addressing the requirement to include “specific services that the home does not provide, but will arrange or coordinate” in the written description of services, Pennsylvania’s personal care compliance guide notes that this means that “a resident with specific needs may be served in a home, but some of the needs will have to be met by outside sources such as local community services” (Pennsylvania Department of Public Welfare). Understanding the scope of service of other organizations can help the aging services provider identify and address gaps and areas of overlap and can facilitate review of contracts (if applicable). It can also aid in communicating options and limitations to residents and family members and in setting realistic expectations.

Figure 13. What to Include in Scopes of Service



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A scope-of-service document should cover four broad categories: direct care services, staffing, ancillary services, and support services (see [Figure 13. What to Include in Scopes of Service](#)). Following are examples of specific elements to consider:

- Mission, goal, and purpose of the service line and levels of care, if applicable
- Population intended to be served
- Description of care and services provided, such as the following:
  - Administration services
  - Direct care (including types and any limitations)
  - Physician services
  - Social services
  - Recreational therapy or activities
  - Dining and nutrition
  - Environmental services (including maintenance, housekeeping, and laundry)
  - Public safety and security
  - Transportation
- Service line demographics, including the number of licensed beds or units in service and a listing of unit types (e.g., private rooms, semiprivate rooms, couples suites, studio apartments, one-bedroom apartments, two-bedroom apartments)
- Hours of operation, if applicable (some services may be unavailable outside of business hours or on weekends)
- Staffing guidelines, such as disciplines, positions, skill levels, and competencies
- Assessment and reassessment guidelines, including the timing and frequency of reassessment
- Affiliated or contracted outside services
- Key services not provided within the scope of service

Sometimes provider organizations raise concerns about addressing staffing in a scope-of-service document because it could create an “unmet standard” if staffing were to fall below what is outlined in the document—and then be used against the organization during litigation. To help avoid such situations, the provider organization might eschew listing staffing ratios and the like, choosing instead to identify general positions and shift breakdowns. Identifying position types and general staffing levels by shift can help provider organizations identify potential changes in staffing needs by discipline, especially when position design is considered in light of the care and services offered.

## Assessments: Determining and Monitoring Needs

To fulfill their duty of care, aging services organizations must align scope of service with the needs of persons served (see [Figure 7. Fulfilling Duty of Care by Matching Scope of Service to Needs](#)). Scope of service is one side of the equation. The other side is the system of processes and practices to determine the needs of the person served, on admission and on an ongoing basis thereafter. Good assessments improve the organization. They enhance the quality of decision-making regarding appropriateness of admission (in relation to the services provided), the need for additional services in a service line, and a need for discharge or transfer to another service line. See “Identifying Individual Needs: Examples of Factors to Assess” for factors that aging services organizations may address.

Assessment tools used to determine resident and patient needs should be aligned with scope of service, so that the information gained in assessments can be used to make decisions regarding admissions, discharges, or bringing in appropriate additional services. For example, although the Minimum Data Set (MDS) has become an assessment to drive financial reimbursement, it is also a comprehensive assessment of resident needs and risks that provides valuable information for care-delivery decisions. Organizations can use the MDS to evaluate ongoing appropriateness in relation to the scope of services provided.

Providers should also use the assessments included in prospective electronic health records (EHRs) as a key decision-making factor when selecting an EHR system. When organizations simply use assessments provided by the EHR developer, it can become a case of function following form. Therefore, due diligence must be used in the selection process to make certain that assessments included provide the information necessary to make determinations about appropriateness of admission and ongoing residency. The selection or development and use of assessments may carry even more weight in settings like assisted living, where required assessments are not as comprehensive as the MDS in skilled nursing.

## Identifying Individual Needs: Examples of Factors to Assess

- Medical history
- Diagnoses (including cognitive and ambulatory deficits)
- Functional assessments - activities of daily living (ADLs)
- Clinical needs
- Areas of risk (e.g., falls, elopement, clinical)
- Psychosocial needs
- Nutritional needs

## Monitoring Organizational Capability and Performance

Ongoing monitoring of performance indicators can help identify risks, contributing factors, and root causes associated with potential mismatches between the needs of those served and the capabilities of the service line and levels of care. Examples include the following:

- Number of incidents and adverse events within 72 hours of admission or readmission. This parameter may vary depending on the service line. For example, the acclimation period to a new environment might be a bit longer for memory support. Incidents that aging services organizations may monitor include the following:
  - Falls with contributing factors
    - Elopements or hazardous wandering events
    - Medication errors
    - Pressure injuries
    - Missed or delayed orders
    - Missed or delayed medication deliveries
    - Allegations of abuse
  - Number of readmissions (transfers) to a higher level of care
  - Completion rates and timeliness of preadmission and admission assessments
    - Falls
    - Memory deficit
    - Elopement
    - Psychiatric issues, including suicide and aggressive behaviors
    - Skin integrity
  - Number of unplanned discharges
  - Number of stays of less than 72 hours
  - Number of residents or patients who discharge against medical advice (AMA)
  - Number of unanticipated deaths
  - Resident and family expectations, satisfaction, and feedback regarding preadmission, admission, and discharge
    - Knowing what to expect
    - Understanding the need for care
    - Understanding the scope of services offered
    - Understanding their needs or the needs of their loved one
  - Occupancy rates

It can also be helpful to track admissions and adverse events by service line, analyzing them by day of week, time of day, and acuity or major diagnoses. Also, monitor these incidents and events in light of occupancy and staffing. As mentioned above, scope of service might contract or expand depending on many factors, including occupancy.

These and other indicators can provide clues about the provider organization's processes for preadmission, admission, discharge, and transition in care. It also offers information about the environment surrounding admissions and whether the environment inhibits incidents and adverse events or causes them to proliferate. In essence, scope of service acts as a guide for decision-making, helping to better match and monitor assessed needs in the persons served with the capabilities of the service line and level of care.

## Action Recommendations

- Develop and maintain a written scope of service for each service line and level of care within each service line. Scopes of service are influenced by many elements over time, including changing customer needs and wants, organizational capabilities, regulations, competition, new services and service lines, and technologies.
- Focus on the organization's preadmission and admission assessment functions. These functions are mission-critical in ascertaining the needs of the person served and determining whether the scope of service can meet those needs. They also provide credible care- and service-related information necessary for staff to deliver services and for those served to understand what care and services to expect.
- Establish a multidisciplinary preadmission screening and decision-making process based on the scope of service for each service line and level of care within the service line. Various regulatory agencies and accreditation bodies establish responsibility for developing and maintaining scope-of-service information and making determinations about the care and services provided by the organization in a given service line or level of care. These can include the provider organization's medical director and the governing body.
- Review regulatory guidelines and requirements when developing, reviewing, and revising scope-of-service documents. Because these are meant to be living documents that are used in decision-making and communications with staff, residents, patients, family members, and care partners, they should accurately reflect such requirements and fluidly evolve with changes in the industry environment.
- Involve your organization's legal counsel when creating scope-of-service documents. This may help ensure that they comply with the varied facets of legal requirements and reduce civil liability.

- Ensure consistent communication regarding scope of service. This involves periodically reviewing marketing materials, the organization’s website, and statements made on social media. It also involves training sales and marketing personnel, as well as others in relevant positions (e.g., receptionists) to communicate a message consistent with the organization’s scope of service for all service lines.
- Establish a decision-making process that identifies individuals who have the authority and responsibility to accept or decline potential admissions. The process should be designed in a way that uses a multidisciplinary approach whenever possible and has enough trained staff for redundancy because there will be times when primary decision makers might be unavailable.
- Review scope-of-service documents on a regular basis and amend as necessary, so that they accurately reflect the care and services provided within the service line. This provides accurate information to decision makers from all stakeholder groups including residents, family members, and staff.



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+1 (610) 825-6000  
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ASIA PACIFIC [asiapacific@ecri.org](mailto:asiapacific@ecri.org)  
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