What's in the Stars
Understanding the New Nursing Home Ratings
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In Race for Medicare Dollars, Nursing Home Care May Lag
Tuesday, April 14, 2015
By Katie Thomas

What is promised by the facilities to lure patients:
• “Decadent” hot baths on demand
• Putting greens
• Gurgling waterfalls to calm the mind

The reporter’s perception of what the homes are doing:
• Investing to make the homes luxurious living quarters
• Using luxurious amenities to lure patients in need of short term rehabilitation after an injury or illness
• Ignoring the needs of those in need of long term care at the end of life
• Not meeting the challenge of providing the intensive care that rehabilitation requires (short on nurses & aides and don’t have doctors on staff)
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**What the reporter hears from the Department of Health:**

- 22% of Medicare patients who stay in a nursing facility for 35 days or less experience harm resulting from their medical care.
- An additional 11% suffered temporary injury.
- Harm experienced in the nursing home cost Medicare $2.8 billion dollars in hospital costs in 2011.

Dr. Arif Nazir, an associate professor of clinical medicine at Indiana University who studies geriatrics stated, “These nursing homes were not built for this purpose. Many patients leave hospitals with acute medical needs, before infections have been fully treated, or as they adjust to new medications. They leave the hospital half-cooked and the latter part of the cooking is the hardest part.”

**Part 1: Objectives**

**Understanding the New Nursing Home Ratings**

- Review the 5 star rating system as a measure of quality and define how measurements are used.
- Define Pros and Cons of the current measurement system.
- Describe how the rating system will impact your facility.
5 STAR RATING SYSTEM

5 STAR RATING SYSTEM

CMS 5-Star Rating Quality System

- Introduced by CMS in December 2008 to enhance its Nursing Home Compare public reporting site.
- Primary Goal: Provide residents and their families with an easy way to understand assessment of nursing home quality by making meaningful distinctions between high and low performing nursing homes.
CMS 5-Star Rating Quality Rating

- Until January 2015 Relied upon data from
  - On-site inspections
    - 3-year survey history of the facility
  - Quality Measures
    - Rating each home against fixed benchmarks (examples: Pressure Ulcers, Restraint use, Injuries, and Falls)
  - Staffing Levels
    - Self-reported data from the facilities on their level of staffing

System was criticized because the information about staffing levels, and some of the QM data, derive from self-reported information from nursing homes that had been challenging to verify.

New System as of Jan 15, 2015

- Highlights
  - verify performance on resident assessments and the data set that is used in QMs for a sample of nursing homes nationwide.
  - The inspections are intended to enhance verification of both the staffing and QM information.
  - Revised scoring methods that place more emphasis on data that is verified by independent sources, rather than data that is self-reported by nursing homes.
  - CMS will increase both the number and type of QMs used at Nursing Home Compare. The first addition (effective January 2015) will measure the extent to which antipsychotic medications are in use.

Applicable Quality Measures

11 of the 18 Quality Measures are Used (8 Long Stay and 3 Short Stay Measures)

Long Stay Residents:
- Percent of residents whose need for help with activities of daily living has increased
- Percent of high risk residents with pressure ulcers (stage 3 or 4)
- Percent of residents who have had a catheter inserted and left in their bladder
- Percent of residents who were physically restrained
- Percent of residents with a urinary tract infection
- Percent of residents who self-report moderate to severe pain
- Percent of residents experiencing one or more falls with major injury

New:
- Percent of residents who received an antipsychotic medication

Short Stay Residents:
- Percent of residents with pressure ulcers (stage 3 or 4) that are new or worsened
- Percent of residents who self-report moderate to severe pain

New:
- Percent of residents who newly received an antipsychotic medication
Quality Measure Clinical Pearls

PAIN MANAGEMENT

Step 1
1. Rapid recognition
2. Make pain relief an urgent priority while looking for cause
3. Be sensitive to subtle signs in residents with cognitive or communication impairment
   • Behavior disturbance
   • Functional decline
   • Poor appetite
   • Insomnia
   • Decline in mood
   • Social isolation
   • Physiologic changes (tachycardia, tachypnea, BP increase, diaphoresis, flushing).

Step 2
1. Assess level of pain
2. Formulate a treatment plan based on level of pain
3. For persistent pain, use standing doses of medications at regular intervals rather than PRN
4. Have availability of "rescue" PRN medication for breakthrough pain
5. Give standing medications on time
6. Provide Adjuvant therapy for pain associated issues such as anxiety, depression, and insomnia.
   • Effectively treating these pain-associated symptoms will enhance the analgesic response.
Pain Management Clinical Pearls
1. PRN stands for “Pain Relief Not!”
2. Start low, go slow, but get there!
3. “Oral” is the preferred route.
4. Don’t confuse tolerance with addiction.
5. Believe what the patient/resident is telling you regarding the tolerability of their pain.
6. Start a “laxative” at the time you start a narcotic analgesic.
7. Patients in significant pain are not likely to suddenly develop respiratory depression from a narcotic analgesic.

Relative Potency of Opioids

<table>
<thead>
<tr>
<th>Opioid</th>
<th>IV Potency</th>
<th>Recommended Dose Range</th>
<th>Tramadol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td>0.1</td>
<td>PO: 10-15 mg q3-hr IV: 10-20 mg q4-hr</td>
<td></td>
</tr>
<tr>
<td>Morphine (Oral)</td>
<td>0.01</td>
<td>PO: 5-20 mg q3-hr IV: 25-50 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Hydromorphone (Oral)</td>
<td>10x less than Morphine</td>
<td>PO: 5-15 mg q3-hr IV: 25-50 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Morphine (IV/ SQ)</td>
<td>0.01</td>
<td>IV/ SQ: 5-10 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Oxycodone (Oral)</td>
<td>0.05</td>
<td>PO: 10-20 mg q3-hr IV: 25-50 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Hydromorphone (IV/ SQ)</td>
<td>0.01</td>
<td>IV/ SQ: 5-10 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Fentanyl (IV/ SQ)</td>
<td>0.01</td>
<td>IV/ SQ: 25-50 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Fentanyl (PO)</td>
<td>0.001</td>
<td>PO: 50-100 mg q3-hr</td>
<td></td>
</tr>
<tr>
<td>Opioid Potency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Least Potent</td>
<td></td>
<td></td>
<td>Tramadol</td>
</tr>
<tr>
<td>Most Potent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Narcotic Box: Dilaudid 2 mg, Roxanol 5 mg, Percocet 3/325 mg, Ultram 50 mg, Vicodin 5/300 mg, Fentanyl 25 mcg.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Half-Life (hr)</th>
<th>Peak Effect (hr)</th>
<th>Duration (hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (IM/ IV/ SQ)</td>
<td>2 - 3</td>
<td>0.5 - 1</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Morphine (PO)</td>
<td>2 - 3</td>
<td>1 - 2</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Controlled-release Morphine</td>
<td>2 - 3</td>
<td>N/A</td>
<td>8 - 12</td>
</tr>
<tr>
<td>Sustained-release Morphine</td>
<td>2 - 3</td>
<td>N/A</td>
<td>12 - 24</td>
</tr>
<tr>
<td>Hydromorphone (IM/ IV/ SQ)</td>
<td>2 - 3</td>
<td>0.5 - 1</td>
<td>3 - 4</td>
</tr>
<tr>
<td>Hydromorphone (PO)</td>
<td>2 - 3</td>
<td>1 - 2</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>2 - 3</td>
<td>1 - 2</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Controlled-release Oxycodone</td>
<td>N/A</td>
<td>3 - 4</td>
<td>8 - 12</td>
</tr>
<tr>
<td>Oxymorphone (IM/ IV/ SQ)</td>
<td>0.5 - 1</td>
<td>3 - 6</td>
<td></td>
</tr>
<tr>
<td>Oxymorphone (PO)</td>
<td>0.5 - 1</td>
<td>3 - 6</td>
<td></td>
</tr>
<tr>
<td>Levorphanol (IM/ IV/ SQ)</td>
<td>12 - 15</td>
<td>0.5 - 1</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Levorphanol (PO)</td>
<td>12 - 15</td>
<td>1 - 2</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Methadone</td>
<td>12 - 150</td>
<td>1 - 2</td>
<td>6 - 8</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>2 - 4</td>
<td>1 - 2</td>
<td>3 - 6</td>
</tr>
<tr>
<td>Fentanyl (IV/ SQ)</td>
<td>7 - 12</td>
<td>&lt; 10 min</td>
<td>1 - 2</td>
</tr>
<tr>
<td>Fentanyl (Transdermal)</td>
<td>N/A</td>
<td>12 - 24</td>
<td>48 - 72</td>
</tr>
<tr>
<td>Fentanyl (Transmucosal)</td>
<td>7 - 12</td>
<td>15 - 30 min</td>
<td>1 - 2</td>
</tr>
</tbody>
</table>
### Tramadol vs. Codeine

<table>
<thead>
<tr>
<th></th>
<th>Tramadol</th>
<th>Codeine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relative Strength (vs. Morphine)</td>
<td>1/10</td>
<td>1/10</td>
</tr>
<tr>
<td>Equivalent Dose</td>
<td>100 mg</td>
<td>100 mg</td>
</tr>
<tr>
<td>Bioavailability</td>
<td>68% - 72%</td>
<td>90%</td>
</tr>
<tr>
<td>Half-life</td>
<td>5.5 - 7 hours</td>
<td>2.5 - 3 hours</td>
</tr>
<tr>
<td>Peak Effect</td>
<td>2 - 3 hours</td>
<td>2 hours</td>
</tr>
<tr>
<td>Duration</td>
<td>3 - 4 hours</td>
<td>4 - 6 hours</td>
</tr>
</tbody>
</table>

**Tolerability Profile in the elderly**

- Has not been shown to cause histamine release that is seen with morphine.
- May produce dizziness, somnolence, nausea, constipation, sweating, pruritis, and seizures.

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### Indwelling Urethral Catheters

**Quality Measure Clinical Pearls**

**INDWELLING URETHRAL CATHETERS**

- Evidence Based Best Practices
  - Continually consider risks verse benefits and discontinue as soon as possible.
  - Hand washing and use of disposable gloves when handling catheter.
  - Maintain a daily fluid intake of 30 ml/kg to flush the system.
  - Disconnection of the catheter and drainage bag is the leading cause of bacterial contamination.
  - 14F or 16F size should be used as larger sizes are more likely to obstruct normal secretions and are more likely to cause infection.
Indwelling Urethral Catheters

- Evidence Based Best Practices
  - Use small balloon (10 cc) as a larger balloon will increase the volume of urine that pools below the lumen and increase risk of infection.
  - Recurrent UTI is an indicator of inadequate perineal care.
  - Urine acidification with cranberry juice, tablets, or vitamin C is controversial but often recommended in clinical practice and is proposed to diminish bacterial count and slow down rate of encrustation.
  - A short (3 day) course of antibiotics at time of removal may reduce risk for subsequent UTI.

Urinary Tract Infection

Diagnosis in the Elderly
- Presence of a single pathogen in the urine (> 100K/80K)
- Reliable Findings:
  - Fever (2.4°F above baseline)
  - Chills
  - New or Increased incontinence, urgency, frequency, or dysuria.
  - Flank pain
  - Blood in the urine
  - Worsening of mental or functional status
  - Confusion, lethargy, or agitation
  - Appearance of the resident
- Less Reliable Findings:
  - Malodorous urine
  - Cloudy urine
  - An isolated fall
  - Skips a meal

Alternate Interventions
- Scheduled toileting
- Improved perineal cleansing
- Increased fluid intake
- Monitor more frequently (example: Vital signs every 4 hours for 3 days)
- For behaviors, wait until cultures are back before deciding to treat. Don’t treat if behaviors are eliminated when the culture returns.

Falls Happen!!!

- 1,800 nursing home death per year due to falls
- 10% - 20% of nursing home falls cause serious injury
- Falls result in functional decline and impact quality of life

Common Causes
- Muscle weakness
- Gait changes and altered center of gravity
- Environmental hazards
  - Wet floors
  - Carpet/Floor transitions
  - Improperly fitted wheelchairs
  - Medications
- Significant change in fall risk for 72 hours after any medication change
- Poor foot care
- Poor fitting shoes

Interventions
- Assessing resident after each fall
  - Address risk factors
    - Assess underlying medical conditions
    - Staff education about fall risk factors and prevention strategies
    - Review prescribed medications to assess risk and benefit
    - Change the nursing home environment to allow for safer movement
    - Encourage use of hip pads
    - Exercise programs for balance, strength, walking ability, and physical functioning
    - Teaching strategies to residents who do not have cognitive impairment.
Quality Measure Clinical Pearls
USE OF ANTIPSYCHOTIC MEDICATIONS

Quality Measures
Included for the First Time to the 5-Star Rating System

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Stay Measures:</td>
<td></td>
</tr>
<tr>
<td>Percent of residents who received an antipsychotic medication</td>
<td>The measure reports the percentage of long-stay residents who are receiving antipsychotic medication. The Food and Drug Administration (FDA) has warned that antipsychotic medications can have significant side effects and are associated with an increased risk of death when used in elderly patients with dementia.</td>
</tr>
<tr>
<td>Short-Stay Measures:</td>
<td></td>
</tr>
<tr>
<td>Percent of residents who newly received an antipsychotic medication</td>
<td>The measure reports the percentage of short-stay residents who are receiving antipsychotic medication during the hospital stay but not on their initial assessment.</td>
</tr>
</tbody>
</table>

Facts Regarding Off-label Use of Antipsychotic Medications in SNFs:
1. In 2012, over 25% of patients in U.S. nursing facilities received an antipsychotic medication according to CASPER data.
2. They were often used to treat behavioral and psychological symptoms associated with dementia (BPSD).
3. These drugs are useful for treating psychotic disorders such as schizophrenia, psychotic symptoms (delusions and hallucinations), and BPSD in certain situations, however, they are often used inappropriately to treat BPSD.
4. In March 2012, CMS launched a facility quality initiative that included a goal to reduce off-label use of antipsychotics by 15%, by December 2012.
5. In September 2014, CMS announced the goal of 15% reduction had been met.
6. The partnership has announced a new goal of 25% reduction by the end of 2015 and 30% reduction by the end of 2016.
### Scoring

<table>
<thead>
<tr>
<th>Rank (Long Stay Measure)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 10%</td>
<td>100 points</td>
</tr>
<tr>
<td>Middle 70%</td>
<td>Divided into three groups of equal size with each group making up 23.3% of the total.</td>
</tr>
<tr>
<td></td>
<td>80 points</td>
</tr>
<tr>
<td></td>
<td>60 points</td>
</tr>
<tr>
<td></td>
<td>40 points</td>
</tr>
<tr>
<td>Bottom 20%</td>
<td>20 points</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank (Short Stay Measure)</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 20%</td>
<td>100 points</td>
</tr>
<tr>
<td>Middle 60%</td>
<td>Divided into three groups of equal size with each group making up 20% of the total.</td>
</tr>
<tr>
<td></td>
<td>80 points</td>
</tr>
<tr>
<td></td>
<td>60 points</td>
</tr>
<tr>
<td></td>
<td>40 points</td>
</tr>
<tr>
<td>Bottom 20%</td>
<td>20 points</td>
</tr>
</tbody>
</table>

### How Does This All Impact You?

**5-Star Impact**

- Relationships
  - The Community: Your future residents
  - Hospitals
  - Managed Care Organizations
  - Accountable Care Organizations

**Confidence**

**Reputation**

**Contracts**

**Referrals**
### Healthcare Reform Finance 101

<table>
<thead>
<tr>
<th>12 Month Review by Diagnosis</th>
<th>Admissions</th>
<th>Readmissions</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>60</td>
<td>16</td>
<td>26.7</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>32</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>COPD</td>
<td>44</td>
<td>3</td>
<td>6.8</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>121</td>
<td>10</td>
<td>8.2</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>230</td>
<td>12</td>
<td>5.1</td>
</tr>
</tbody>
</table>

### Partners in Care

*You Still Have to Prove Yourself!!!*

- **How are SNF’s Viewed Within the Continuum?**
  - The source of many readmissions
  - They could do a better job of providing appropriate follow-up care
    - Admit within 24 hours
    - Daily visits for the first 3 days
  - They could do a better job of coordinating transitions with the hospitals
  - They need to provide higher levels of intensity in managing severely ill patients
Alert!!!
The local hospital is concerned that the rate of acute care transfers, including 30-day readmissions, are rising from your center! They are particularly concerned about the prevalence of transfers diagnosed with sepsis.

Septicemia

- 6th most common reason for hospitalization in the US
- The most expensive reason for hospitalization in 2009 ($15.4 billion)
- 1 out of every 23 hospitalized patients carry the diagnosis (4.2%)
- 16% in-hospital mortality rate (more than 8 times higher than other stays)
- Septicemia-related stays more than doubled from 1993 to 2009 (6% average annual increase)
- Medicare was the predominant payer
- Most common organism was E.coli for patients with a principle dx and MRSA for patients with secondary dx of septicemia
- Complication of device, implant, or graft was most common principle cause (one of every five related stays)
Trinity of Sepsis
"We have to reduce ___ hospitalization rates ___"

The mean age of admitted patients is 60.3. You are more susceptible for the condition with advancing age.

E.D. Statement: "If only they had _____ him/her here _____ we could have _____ him/her"

Common Secondary Dx
1. Dehydration
2. Electrolyte imbalance
3. Acute Renal Failure
4. Respiratory Failure
5. Shock

You have an at risk population

E. Coli is the most common pathogen found on blood culture results, though in many cases no organism is identified.

You have the pathogens

E.D. Statement: "If only they had sent him/her here sooner we could have saved him/her"

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QA Report - Transfers for Sepsis

<table>
<thead>
<tr>
<th>Day</th>
<th>Shift</th>
<th>Change in Condition</th>
<th>E.D. Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mon</td>
<td>Eve</td>
<td>SOB/ Wheezing (4 days)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Sat</td>
<td>Eve</td>
<td>*Dislodged nephrectomy tube (&lt; 24h)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Sun</td>
<td>Day</td>
<td>Lethargy, Hyoxia (88%), Cough, Fever (&lt; 24h)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Mon</td>
<td>Day</td>
<td>Shortness of breath &amp; Hyoxia - 45% (1 day)</td>
<td>Septic shock</td>
</tr>
<tr>
<td>Wed</td>
<td>Day</td>
<td>*Unresponsive &amp; Hypotensive (&lt; 24)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Fri</td>
<td>Day</td>
<td>*Shortness of breath (&lt; 24h)</td>
<td>Sepsis/ Cardiac Arrest</td>
</tr>
<tr>
<td>Sat</td>
<td>Eve</td>
<td>*Painful penis swelling/Pus on meatus (&lt;24h)</td>
<td>Sepsis/ Abscess</td>
</tr>
<tr>
<td>Mon</td>
<td>Eve</td>
<td>*Moaning and refusing to eat (&lt; 24h)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Wed</td>
<td>Night</td>
<td>Hematuria, chills, abnormal CXR (&lt;24h)</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Fri</td>
<td>Day</td>
<td>Sodium 146 with rising BUN and Creatinine</td>
<td>Renal failure/ Sepsis</td>
</tr>
<tr>
<td>Wed</td>
<td>Day</td>
<td>*Sent to E.D. from oncologist’s office</td>
<td>Sepsis/ Neutropenia</td>
</tr>
<tr>
<td>Mon</td>
<td>Day</td>
<td>*Sent from dialysis center due to hypotension</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Thu</td>
<td>Eve</td>
<td>New wheezing and cough while on ABX (&lt;24h)</td>
<td>Sepsis/ Pneumonia</td>
</tr>
<tr>
<td>Tue</td>
<td>Day</td>
<td>Fever 100.1/ Unable to start IV line</td>
<td>Sepsis</td>
</tr>
</tbody>
</table>

*No interventions prior to transfer
QA Report – Transfers for Sepsis

- Most transfers occurred between 9 AM – 11 AM (4) and 3 PM – 4 PM (3).
- 9 transfers were not avoidable
- 2 transfers were not dictated by the facility
  - Oncology office
  - Dialysis
- The case of the dislodged nephrectomy tube occurred because family tried to position resident without informing staff
- One resident had just recovered from an episode of MRSA sepsis (30-day Readmit)
- Oncologist transferred patient to E.D. due to findings of leukopenia

Graded Interventions Prior to Transfer

- A. On-Site Medical Evaluation
- B. IV Fluids
- C. Medication Change
  - A. Add/DC/Change Dose
- D. Oxygen Therapy
- E. Diagnostic Test Ordered
- F. Order Increased Oral Fluids
- G. Specialist Consultation
- H. Prior E.D. Transfer
- I. No Intervention

Graded Interventions Prior to Transfer - Cases With No Interventions

1. Dislodged nephrectomy
2. Unresponsive/Hypotensive
3. Shortness of breath
4. Painful penile swelling
5. Moaning and not eating
6. Sent from oncologist office due to leukopenia
7. Sent from dialysis due to hypotension
67-year old male with an indwelling Foley catheter secondary to BPH was found in respiratory distress at 3 AM. He was cool and clammy. His vital signs were Temperature 99.0 (oral); Blood Pressure 90/50; Respiratory rate 24 and labored using accessory muscles, and pulse 118 and regular. His oxygen saturation was 80% on room air and his finger-stick blood glucose was 245 mg/dl. Oxygen was given using a non-rebreather and his oxygen saturation improved to 91%.

A physician covering for the attending was called and ordered transfer to the emergency room. The residents wife was notified and he was transferred.

At the hospital he was diagnosed as having septicemia, was intubated, and admitted to the intensive care unit.

The physicians in the emergency room informed the resident’s wife that his condition was grave and that he could have been saved if the nursing home had sent him 12 hours sooner or at least started IV fluids 12 hours earlier.

The following day, the resident died in the ICU.
Aftermath

- The resident’s wife, angered by comments made by the ER physicians, wants to know
  1. Why wasn’t she called when her husband had a change in condition 12 hours prior to hospital transfer?
  2. Why did the facility delay treatment for 12 hours thus causing a wrongful death?

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:30 AM</td>
<td>T 97.9; P80; R20</td>
</tr>
<tr>
<td></td>
<td>Covering MD notified that the resident is complaining of burning at his catheter site. His Foley was irrigated with clean return. MD ordered U/A &amp; culture and started pyridium 100 mg BID.</td>
</tr>
<tr>
<td>3:00 PM</td>
<td>T 98.8; P74; R20</td>
</tr>
<tr>
<td></td>
<td>MD that had been called at 4:30 AM examines resident and orders a bladder scan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM</td>
<td>BP 138/74; P74; R20</td>
</tr>
<tr>
<td></td>
<td>No significant clinical events occur on this date</td>
</tr>
</tbody>
</table>
### Monday

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:15 PM</td>
<td>T 98.7; P 74; R 20</td>
</tr>
<tr>
<td></td>
<td>Seen by NP to follow up response to pyridium. He was not complaining of burning any longer and was having no apparent reactions to pyridium.</td>
</tr>
</tbody>
</table>

### Tuesday

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:10 PM</td>
<td>Nursing observes that the resident’s speech is slurred. Oxygen is applied. Pulse oximetry after 30 minutes was 97%.</td>
</tr>
<tr>
<td></td>
<td><strong>T -12H</strong> P 88; Temp 97.6</td>
</tr>
<tr>
<td>3:30 PM</td>
<td>P 62; R 16; BP 105/65; Pulse Oximetry 96%</td>
</tr>
<tr>
<td></td>
<td>NP called to assess resident</td>
</tr>
<tr>
<td>3:45 PM</td>
<td>NP assessed resident who was no longer with slurred speech and insisted he wanted to go outside and smoke. U/A reviewed and bactrim started. Increased oral fluids also ordered.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:00 PM</td>
<td>1st dose of bactrim taken from the emergency box and given.</td>
</tr>
<tr>
<td>9:30 PM</td>
<td>T 97.9; P 66; R 18; BP 108/70</td>
</tr>
<tr>
<td></td>
<td>Nurses noted that the resident had not passed any urine during the shift. Upon assessment they discovered that his Foley catheter was dislodged. A new Foley catheter was inserted with immediate return of 800 cc of bloody urine.</td>
</tr>
</tbody>
</table>
Wednesday

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 AM</td>
<td>BP 102/60; P 70; R 20; T 98.9</td>
</tr>
<tr>
<td></td>
<td>Foley catheter with rust colored urine.</td>
</tr>
<tr>
<td>3:00 AM</td>
<td>-Found in respiratory distress, cool, and clammy</td>
</tr>
<tr>
<td></td>
<td>-T 99; P 118; R 24; BP 90/50; Pulse Oximetry 70%</td>
</tr>
<tr>
<td></td>
<td>-Foley catheter with frank hematuria</td>
</tr>
<tr>
<td></td>
<td>-Oxygen applied and saturation improved</td>
</tr>
<tr>
<td>3:15 AM</td>
<td>Attending MD called and ordered transfer to the ER, 15 minutes after being observed to have a significant change in condition.</td>
</tr>
</tbody>
</table>

Sepsis Risk Checklist

- Confusion/Dementia
- Impaired Mobility
- Incontinence of Urine
- Incontinence of Bowel
- Decubiti
- Indwelling Urinary Catheter
- Gastrostomy Tube

Checklist items based on clinical evidence that LTC residents with bacteremia were highly functionally impaired and characterized by confusion or dementia (62%), impaired mobility (79%), incontinence of urine (55%) and bowel (34%), presence of decubiti (12%), use of indwelling urinary catheter (14%), presence of gastrostomy tube (10%).

Alert!!!

A local ACO is concerned that your length of stay for sub-acute patients, at 27 days, is longer than they are experiencing with other facilities. They want you to target getting patients out in 20 days or less.
Alert!!!

A local ACO is concerned that your length of stay for sub-acute patients, at 27 days, is longer than they are experiencing with other facilities. They want you to target getting patients out in 20 days or less.

<table>
<thead>
<tr>
<th></th>
<th>&lt; 24H</th>
<th>24 - 72H</th>
<th>4 - 7 Days</th>
<th>8 - 14 Days</th>
<th>15 - 20 Days</th>
<th>20 - 30 Days</th>
<th>&gt; 30 Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number</td>
<td>3</td>
<td>19</td>
<td>19</td>
<td>14</td>
<td>7</td>
<td>1</td>
<td>91</td>
</tr>
<tr>
<td>Transfers per day (for the time period)</td>
<td>3.0</td>
<td>6.3</td>
<td>4.5</td>
<td>2.7</td>
<td>1.4</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Avoidable</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>% Avoidable for period</td>
<td>33%</td>
<td>15.8%</td>
<td>38.9%</td>
<td>26.3%</td>
<td>14.3%</td>
<td>46.7%</td>
<td>18.7%</td>
</tr>
</tbody>
</table>

Questions?

Part 2: Objectives

Quality Care 1-2-3 Approach

- Discuss ways a facility can pull together current assessments while incorporating new assessments that will transform the QA culture.
- Recognize the role of both the medical director and medical staff as a team approach to the entire process of antipsychotic drug monitoring.
- Describe how adequate staffing helps create the best team.
The Hospitalization Issue & QAPI
How Does it Pertain to Long Term Care

1. CMS is concerned about potentially avoidable hospitalizations (PAHs).
2. PAHs are defined as hospitalizations that could have been avoided because the condition could have been prevented or treated outside of an inpatient setting.
3. 26% of hospitalizations are considered PAHs.
   - Average patient stay per PAH is 6.1 days.
   - Average total annual cost to Medicare is $8 billion.
   - Nursing Homes house 16% of Medicare beneficiaries yet account for 45% of all PAHs.
4. Multiple programs have been developed to reduce the frequency of PAHs over the past several decades.
4 Basic Questions

1. Who am I?
2. What am I doing here?
3. Where did I come from and how did I get here?
4. Where am I going and how do I get there?

Are there any strategies currently being used that have been shown to reduce hospitalization rates that can be implemented in a system that is similar to mine?

Strategies Used by Hospitals

<table>
<thead>
<tr>
<th>Strategy That Could Be Applied in the Long Term Care Environment</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Driven Strategies</td>
<td>30%</td>
</tr>
<tr>
<td>Disease management</td>
<td>99%</td>
</tr>
<tr>
<td>Fall Prevention</td>
<td>66%</td>
</tr>
<tr>
<td>Medication Management</td>
<td>59%</td>
</tr>
<tr>
<td>Patient/ Caregiver Education</td>
<td>48%</td>
</tr>
<tr>
<td>Telehealth</td>
<td>8%</td>
</tr>
<tr>
<td>Management culture and support</td>
<td>61%</td>
</tr>
<tr>
<td>Physician Relationship</td>
<td>57%</td>
</tr>
</tbody>
</table>
Is there anything to be learned from data driven strategies that relate to disease state management?

Potentially Avoidable Hospitalizations

• 5 conditions have been found to be responsible for nearly 80% of Potentially avoidable hospitalizations:

1. Congestive Heart Failure
2. COPD/ Asthma
3. Urinary Tract Infections
4. Pneumonia
5. Dehydration/Acute Kidney Injury
Strategies for Heart Failure
Evidence Shows that the SNF Can’t Do it Alone

1. Major Impact Strategies
   1. Coordination of care between hospitals (-0.34%)
   2. Partnering with community physicians (-0.33%)

2. Other Helpful Strategies
   1. Assigning staff to follow-up on post-discharge test results (-0.26%)
   2. Sending discharge summaries directly to MD taking the case (-0.21%)
   3. Scheduling follow-up appointments (-0.19%)
   4. Giving nurses the responsibility of medication reconciliation (-0.18%)

Source: Waknine, Y Medscape Medical News; July 31, 2013

Strategies for Heart Failure
Evidence Shows that the SNF Can’t Do it Alone

4 Strategies Associated with Increased Hospitalization Rates for Heart Failure
1. Alerting outpatient physicians of discharge within 48 hours (+0.42%)
2. Providing a written emergency plan on discharge (+0.38%)
3. Providing follow-up calls with additional education for discharged patients (+0.34%)
4. Electronic linking of inpatient and outpatient prescription records (+0.18%)

Source: Waknine, Y Medscape Medical News; July 31, 2013

Strategies for COPD/Asthma

- Patient has been clinically stable for at least 12 hours prior to discharge.
- Pulmonary rehab if indicated.
- Assurance of effectiveness of maintenance medication regimen.
- Appropriate inhaler technique.
- Appropriate use of long term oxygen therapy.
- An appropriate plan to manage co-morbid conditions.
Strategies for COPD/Asthma

• ATS Criteria for Pulmonary Rehabilitation
  1. Presence of dyspnea or other respiratory symptoms.
  2. Reduced exercise tolerance.
  3. A restriction in activities because of disease.
  4. Impaired general health status.

Strategies for UTI's

Too Many Signals Here!!!!!!!

Asymptomatic Bacter-What?
No Fever
No Frequency
No Burning
No Flank Pain

UTI's don't cause behaviors; or do they?

UTI?! But that's not what I sent her for?

Cultures back, behaviors gone, covering physician treats, now they have C. Diff.

Strategies for Pneumonia

• Immunization for influenza and pneumococcus when indicated to improve long-term burden of the disease.
• Ensure medications are being used correctly.
• Monitor for signs and symptoms that suggest worsening of the underlying condition.
  – Sputum, cough, SOB, hypoxia, fever
• Following the admission H&P there should be a one week follow-up to assess response to treatment.
Strategies for Dehydration/Acute Kidney Injury

Broad Issues

Limited, If any, Specific Evidence

Be Sensitive to Serum Sodium Levels

Fall prevention is the most frequently used strategy (66% implementation rate) listed & I have residents that fall, but are falls really having an impact on my acute care transfer and hospitalization rate?

During the 1st quarter the most prevalent admitting diagnoses were UTI (27.9%), CHF (10.7%), TIA (7%), and Metabolic Acidosis (7%). The most common this quarter was traumatic injury.

9/62 (14.5%) diagnosed with traumatic injury
Evidence Based Fall Risk Assessment

<table>
<thead>
<tr>
<th>Measure Assessed</th>
<th>Tool</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leg strength &amp; Endurance</td>
<td>30-second chair stand test</td>
<td>Start seated in chair, examiner says &quot;Go&quot; and resident must stand up and return to seated position as many times as possible in 30 sec.</td>
</tr>
<tr>
<td>Static Balance</td>
<td>4-stage balance test</td>
<td>Perform and hold 4 increasingly difficult standing positions for 10 seconds.</td>
</tr>
<tr>
<td>Balance</td>
<td>Berg functional balance scale</td>
<td>Perform 14 predetermined tasks such as standing on one leg.</td>
</tr>
<tr>
<td>Fear of falling</td>
<td>Falls efficacy scale</td>
<td>Resident rates his/her confidence at being able to perform 10 non-hazardous ADL's.</td>
</tr>
<tr>
<td>Mobility</td>
<td>Timed get up and go test</td>
<td>Series of timed tasks performed that are needed for independent mobility such as standing from seated position, walking, turning, stepping, &amp; sitting down.</td>
</tr>
<tr>
<td>Gait &amp; Balance</td>
<td>Tinetti assessment tool</td>
<td>Resident performs a series of maneuvers during which various abilities and characteristics are observed.</td>
</tr>
</tbody>
</table>

Accident & Incident Report

**Incident:** Resident found on floor between his bed and wheelchair in his room with no injury at 8 PM. MD notified. No new orders.

**Medical History:** Parkinson’s disease and Mild Cognitive Impairment.

**Function:** Walking has recently become gradually more difficult for him. He used to walk independently but now needs a wheelchair to go between his room and the dining room & he can’t seem to adjust.

**Behaviors:** He is upset over his loss of independence and his attempts to continue to try to do things beyond his abilities led to this fall.

**Conclusion:** The resident fell because he has poor awareness of safety and difficulty coping with his deteriorating physical abilities.

**Plan:** (1) Chair alarm; (2) Wedge cushion for chair; (3) Remind resident to use call light for assistance when he needs to transfer.

Interdisciplinary Root Cause Analysis

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why did he try to get up?</td>
<td>He is upset about not being able to walk anymore.</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Why can’t he walk anymore?</td>
<td>He is weaker and seems to be getting more stiff.</td>
<td>Nurse</td>
</tr>
<tr>
<td>Why is he weaker?</td>
<td>He lost 4% of his weight last month.</td>
<td>Dietician</td>
</tr>
<tr>
<td>Why is he stiff?</td>
<td>He is pending follow-up with neurologist to assess the status of his Parkinson's disease.</td>
<td>Nurse</td>
</tr>
<tr>
<td>Is a medication adjustment needed?</td>
<td>It may not be a medications issue. Immobility can cause stiffness and muscle weakness.</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>Why is he losing weight?</td>
<td>His meal intake use to be 85% - 100% but for several weeks it has been &lt; 50%.</td>
<td>Dietician</td>
</tr>
<tr>
<td>Why is he eating less?</td>
<td>He has a small sore in his mouth that has been bothering him for a while. He wife visits and says he gets this from time to time and didn’t think it was a big deal but when he gets them he won’t wear his dentures.</td>
<td>Nursing Assistant</td>
</tr>
</tbody>
</table>
Two Plans of Care

Scenario 1 – The Quick Fix Cookie Cutter Approach
- Chair alarm.
- Wedge cushion while sitting in wheelchair.
- Remind resident to use call light for assistance with transfers.
- Medical director and consultant pharmacist to do a medication review.
- Update care plan for nine or more medications.

Scenario 2 – The IDC Plan that included the C.N.A.
- Conduct a comprehensive oral assessment and treat his oral impairment.
- Modify his diet to improve his nutritional status.
- Follow-up on the status of when the neurologic assessment will be done.
- Schedule a physical therapy consult to provide muscle strengthening and improve balance.

Patient and Caregiver education was implemented by 48%. Where would be a good place for me to start that could have significant impact on my acute care transfer rate?

The Power of Palliative Care
### Disease Trajectory

![Disease Trajectory Chart](image)

**Holley JL CJASN 2012; 7:1033-1038**

#### 1. Basic Disease Process
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Cancer</td>
</tr>
<tr>
<td>b.</td>
<td>Advanced COPD</td>
</tr>
<tr>
<td>c.</td>
<td>Stroke (with decreased function by at least 50%)</td>
</tr>
<tr>
<td>d.</td>
<td>End-stage renal disease</td>
</tr>
<tr>
<td>e.</td>
<td>Advanced cardiac disease – i.e., CHF, severe CAD, CH (LVEF &lt; 25%)</td>
</tr>
<tr>
<td>f.</td>
<td>Other life-limiting illness</td>
</tr>
</tbody>
</table>

**SCORING:**
- Select an option and write the score in the space provided.

#### 2. Concurrent Disease Processes
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Liver disease</td>
</tr>
<tr>
<td>b.</td>
<td>Moderate renal disease</td>
</tr>
<tr>
<td>c.</td>
<td>Other condition complicating care</td>
</tr>
<tr>
<td>d.</td>
<td>Moderate COPD</td>
</tr>
<tr>
<td>e.</td>
<td>Moderate congestive heart failure</td>
</tr>
</tbody>
</table>

**Score 1 point overall**

#### 3. Functional status of patient

**Using ECOG Performance Status (Eastern Cooperative Oncology Group):**

<table>
<thead>
<tr>
<th>ECOG Grade</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry out all pre-disease activities without restriction.</td>
</tr>
<tr>
<td>1</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light nature, e.g., light homemaking, office work.</td>
</tr>
<tr>
<td>2</td>
<td>Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.</td>
</tr>
<tr>
<td>3</td>
<td>Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.</td>
</tr>
<tr>
<td>4</td>
<td>Completely disabled; cannot carry on any self-care. Totally confined to bed or chair.</td>
</tr>
</tbody>
</table>

**Score 0-3**

#### 4. Other criteria to consider in screening

<table>
<thead>
<tr>
<th></th>
<th>Score 1 point EACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Has one or multiple level of pain &gt; 24 hours</td>
</tr>
<tr>
<td>b.</td>
<td>Has uncontrolled symptoms (i.e., nausea, vomiting)</td>
</tr>
<tr>
<td>c.</td>
<td>Has uncontrolled psychosocial or spiritual issues</td>
</tr>
<tr>
<td>d.</td>
<td>Has frequent visit to the Emergency Department (&gt; 1 x mo for same diagnosis)</td>
</tr>
<tr>
<td>e.</td>
<td>Has more than one hospital admission for the same diagnosis in last 30 days</td>
</tr>
<tr>
<td>f.</td>
<td>Has prolonged length of stay without evidence of progress</td>
</tr>
<tr>
<td>g.</td>
<td>Has prolonged stay in ICU(s) without evidence of progress</td>
</tr>
<tr>
<td>h.</td>
<td>Is in an ICU setting with documented poor or futile prognosis</td>
</tr>
<tr>
<td>i.</td>
<td>Is not a candidate for curative therapy</td>
</tr>
<tr>
<td>j.</td>
<td>Has a life-limiting illness and chosen not to have life-prolonging therapy</td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

**SCORING GUIDELINES:**
- **TOTAL SCORE = 2** Give patient Palliative Care information brochure
- **TOTAL SCORE = 3** Consider Palliative Care consult; give info to patient
- **TOTAL SCORE = 4** Palliative Care consult recommended (requires physician order)

**W** Would you be surprised if this patient died within the next 6 months? **YES** **NO**

**If NO, consider Hospice referral.**

#### Palliative Care Checklist
- Understanding of prognosis
- Understanding of current and future symptoms
- Advance Directives/MOLST
Benefits
You have developed fever, an abnormal heart rate, shortness of breath, uncontrollable pain, vomiting that doesn’t respond to medication and can’t get comfortable

- Ready availability of lab tests, x-rays, and other diagnostic tests.
- Daily access to doctors and specialists.
- Availability of surgery and other procedures that may help.
- Intensive care units if the situation becomes critical.

Risks
- Complications can occur even in the best hospitals.
- Chronic medical problems and potentially age increase your risk for complications.
- Complications include
  - Being in an unfamiliar environment.
  - New or worsening confusion.
  - More time spent in bed increasing risk for clots, pressure wounds, muscle weakness, and loss of function.
  - Less sleep and rest due to tests, monitoring, and noise.
  - Increased risk for falls with injuries.
  - New infections.
  - Depression due to limited opportunities to socialize with friends and family.

Risks if Hospitalized from a Nursing Home
- Disruption of continuity of care.
- Loss of familiar routines.
- Uncomfortable ambulance ride to the hospital.
- Long wait in the emergency room.
- Miscommunications between the hospital and nursing home.
Hospital Care

- **What can you do to avoid unnecessary hospitalizations**
  - Have proactive discussions with your health care provider about treatment preferences.
  - When a new symptom is recognized have discussions about risks and benefits of a hospital transfer.
  - Complete an advance directives document that outlines preferences for care in emergencies at the end of life.
  - Understand the extent of treatment that can be given in the current care setting.

ANTIPSYCHOTIC DRUG MONITORING

Medical Director's Role

Care Plan Management

- **Goals of the Medical Director**
  - Assist the nursing staff in developing a formal thought process for improving dementia care
  - Encourage creative thinking by providing a baseline roster of ideas broken down by category
  - Avoid unnecessary use of medication(s) with particular attention to off-label use of antipsychotics and appropriate recognition and management of depression
Mary

**Reports:** Mary is a 92-year-old female who has been a resident of the facility for more than 6 years. She is a widow and often speaks to the nurses and the nursing assistants about how much she misses her husband and likes to reminisce about the times she spent with him.

**Observations:** When she is talking about her husband it seems to put her in a good mood, but at other times she is sad.

**Background:** She was a housewife who helped her husband run a bar that they owned.

**Conclusions:** None of the staff feel anything needs to be done.

---

Eleanor

**Reports:** Eleanor likes to sit in front of the nurses station every night after she finishes her dinner. She will start a conversation with anyone that will sit near her and often likes to talk about the days when she was working. She frequently will ask to be toileted, and if one of the aides doesn't get to her within a few minutes she gets very agitated and starts to yell and scream and become generally disruptive. Her yelling gets louder the longer she has to wait.

**Observations:** Her toileting needs seem to occur when she observed staff helping others.

**Background:** She is a diabetic who worked as a nurse.

**Conclusions:** The staff feels she needs an evening anxiety medication to take the edge off.

---

Joe

**Reports:** Wanders through the unit all night and frequently goes into other resident’s rooms. Sometimes he just stares at you looking as if he’s ready to attack. Many of the residents, especially the females, are terrified.

**Observations:** He wanders all the time and doesn’t sleep much. He has been an acquaintance of several residents that are in the facility for years. One (Mary) states that they were friends but he has recently turned on her.

**Background:** A veteran of World War II

**Conclusions:** He needs a medication to control his wandering behavior. Klonopin was tried but he became more agitated.
Step 1A: Root-Cause Analysis

Potential Causes (Antecedents) by Category

- Event physical needs
  - Pain
  - Infection/Injury
  - Dehydration/Nutrition
  - Sleeping
  - Sexual
  - Reproductive
  - Autonomic
  - Sensory/Nutritional

- Event psychological needs
  - Emotional
  - appetitive, worry, fear
  - Functional disorganization
  - physical
  - Social isolation
  - Activity
  - Lack of interest/energy

- Environmental causes
  - Level of interaction
  - noise, confusion, lighting
  - Cognitive approaches
  - Institutional rules, expectations
  - Environmental support
  - Function & way-finding

- Psychiatric causes
  - Depression
  - Anxiety
  - Delirium
  - Psychosis
  - Other mental health

Joe
- Wanders
- Other rooms
- Stares
- Intense
- Poor sleep
- Failed Klonopin

The staff reported that because Joe was wandering, and because he was worse on Klonopin that it would be better to treat him with an antipsychotic to stop his wandering into other rooms.

Wandering
Poor Self-Care
Restlessness
Nervousness
Mild Anxiety
Fidgeting
Appropriate Use of Antipsychotics

**Appropriate Targets**
- Physically Aggressive Behavior
- Hallucinations
- Severe Distress
- Delusions (Do not confuse with memory problems)

**Inappropriate Targets**
- Wandering
- Poor Self-Care
- Restlessness
- Nervousness
- Mild Anxiety
- Fidgeting

---

**Step 1A: Root-Cause Analysis**

**Potential Causes (Antecedents) by Category**

- **Event physical needs**
  - Pain
  - Nutrition
  - Daily hygiene
  - Sleep disturbances
  - Mobility
  - Sensory deficits
  - Comprehension
  - Insensate responsiveness

- **Event psychological needs**
  - Loneliness
  - Restlessness
  - Apprehension, worry, fear
  - Emotional discomfort
  - Lack of meaningful activities
  - Loss of identity

- **Environmental stress**
  - Level of stimulation
  - Noise, confusion, lighting
  - Congruent approaches
  - Instructional inadequacies
  - Lack of interaction
  - Lack of routine
  - Task or pace is too much

- **Psychotropic cause**
  - Hallucinations
  - Delusions
  - Anxiety
  - Depression
  - Psychotic
  - Other mental illness

---

**Eleanor**
- Sits and watches
- Likes to talk
- Likes attention
- Impatient
- Loud & Disruptive
- Diabetic (Polyuria?)
- Controlled
- Anxiety Medication?

**She needs companionship and a sense of belonging.**

---

**Step 1A: Root-Cause Analysis**

**Potential Causes (Antecedents) by Category**

- **Event physical needs**
  - Pain
  - Nutrition
  - Daily hygiene
  - Sleep disturbances
  - Mobility
  - Sensory deficits
  - Comprehension
  - Insensate responsiveness

- **Event psychological needs**
  - Loneliness
  - Restlessness
  - Apprehension, worry, fear
  - Emotional discomfort
  - Lack of meaningful activities
  - Loss of identity

- **Environmental stress**
  - Level of stimulation
  - Noise, confusion, lighting
  - Congruent approaches
  - Instructional inadequacies
  - Lack of interaction
  - Lack of routine
  - Task or pace is too much

- **Psychotropic cause**
  - Hallucinations
  - Delusions
  - Anxiety
  - Depression
  - Psychotic
  - Other mental illness

---

**James**
- The boxer answering the bell.
- An example of the importance of following the ABC’s of behavior management.

---

**Learn the ABC’s**
- Get rid of the stimulation created by that bell!
Step 1A: Root-Cause Analysis

Potential Causes (Antecedents) by Category

- Emotional/mental issues
  - Sadness
  - Depression
- Physical health
  - Medication side effects
- Environmental
  - Lack of social activities
- Economic
  - Inadequate income

Mary
- Misses her husband.
- Sad at times.
- Seems to tolerate it well.
- No psychotherapy or medication.

Step 1B: Treatment Plan & Response

- All treatment plans are formulated based on a problem (antecedent) list generated from the items above.
- The goal of the assessment is to identify all potential antecedents.
- The goal of therapy is to eliminate the antecedent(s) to the extent possible.
- The resident is to be monitored and response to treatment (or failure of response) should be documented.

Case Study

Joe was treated with Klonopin, not for his wandering behavior, but for symptoms of anxiety that he seemed to be displaying. Prior to Klonopin being started a medical workup was done that excluded constipation, pain, infection, and other potential pertinent medical problems. He became violent while on Klonopin and the medication was discontinued. His behaviors gradually became worse after Klonopin was discontinued and he did not respond to any non-pharmacologic interventions. As time passed he became an increasing physical threat (physically aggressive behavior) to residents, staff, and the environment.
Failure to Respond (Step 2)

If antecedents cannot be identified, or if antecedents have been identified but cannot be extinguished or continue to be a problem, proceed to step 2.

The foundation of non-drug interventions will be based on adjusting caregiver approach as needed, making necessary changes to the environment as possible, and making use of any reasonable evidence-based interventions.

Case Study - Continued

Eventually, after exhausting all non-pharmacologic interventions that could be thought of, Joe was treated with a low dose Seroquel. Within 4 weeks of starting the medication he showed a dramatic improvement in symptoms without developing any cognitive or functional decline.

Any initiation of an antipsychotic medication should be reported to the D.O.N. & Medical Director.

Step 3

- Quantify behavioral symptoms using rating scale(s).
- If antipsychotics must be used document indication & assure adequate "dose" with reference to intensity, duration, and frequency.
- At the start, plan for the first GDR attempt.
- Provide and reinforce staff training and development activities to assure full understanding and cooperation in daily care.
- Continue to adapt and add interventions as needed to achieve optimal outcomes.
Stages & Progression of Major Depressive Disorder

- Euthymia
- Progression to Disorder
- Response
- Remission
- Relapse
- Treat to eliminate residual symptoms and to reduce risk of relapse.

Treatment Phase
- Acute
- Continuation/Maintenance

Treatment Goals
- Achieve Remission
- Delay Time to Relapse

Antidepressant Prescribing

- Indications: These agents are usually prescribed for a variety of conditions, other than depression, that include:
  - Anxiety disorders
  - Post-traumatic stress disorder
  - Obsessive compulsive disorder
  - Insomnia
  - Neuropathic pain (example: diabetic peripheral neuropathy)
  - Migraine Headaches
  - Urinary Incontinence
  - Fibromyalgia
- Use of two or more simultaneously may increase the risk of side effects. In such cases there should be documentation of expected benefits that outweigh the associated risks and monitoring for any increase in side effects.
Adverse Profiles of Selected Agents

<table>
<thead>
<tr>
<th>Celexa</th>
<th>Remeron</th>
<th>Trazodone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania</td>
<td>Mania</td>
<td>Serotonin Syndrome</td>
</tr>
<tr>
<td>Serotonin Syndrome</td>
<td>Orthostatic Hypotension</td>
<td>Orthostatic Hypotension</td>
</tr>
<tr>
<td>Hypnaetremia</td>
<td>Torsades de pointes</td>
<td>QT Prolongation</td>
</tr>
<tr>
<td>EPS</td>
<td>Seizures</td>
<td>Cardiac arrhythmias</td>
</tr>
<tr>
<td>Seizures</td>
<td>Glaucoma, angle-closure</td>
<td>Nausea/Vomiting</td>
</tr>
<tr>
<td>Hyponatremia</td>
<td>Nausea/Vomiting</td>
<td>Blurred vision</td>
</tr>
<tr>
<td>Abnormal bleeding</td>
<td>Increased Confusion</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Nausea/ Vomiting</td>
<td>Orthostatic Hypotension</td>
<td>Glaucoma/angle-closure</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>Dizziness</td>
<td>Hyponatremia</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Peripheral edema</td>
<td>Syncope</td>
</tr>
<tr>
<td>Nervouness</td>
<td>Black pain</td>
<td>Torsades de pointes</td>
</tr>
<tr>
<td>Torsades de pointes</td>
<td>Myalgia</td>
<td>Urinary frequency</td>
</tr>
</tbody>
</table>

*Red indicates presence in multiple columns.*

GDR Requirement Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>1st Year</th>
<th>Subsequent Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic</td>
<td>Must be attempted in 2 separate quarters with at least one month between attempts, unless clinically contraindicated.</td>
<td>GDR must be attempted annually except where clinically contraindicated.</td>
</tr>
<tr>
<td>Antidepressant (MDD)</td>
<td>Use as per standards of practice in community per clinical practice and evidence based guidelines.</td>
<td>Same as antipsychotics</td>
</tr>
<tr>
<td>Antidepressant (Other)</td>
<td>Same as antipsychotics</td>
<td>Same as antipsychotics</td>
</tr>
<tr>
<td>Sedatives</td>
<td>Quarterly taper if being used routinely and beyond the time manufacturer recommends for use</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Hypnotics</td>
<td>Same as sedatives</td>
<td>Same as sedatives</td>
</tr>
</tbody>
</table>

Prior to discontinuation, many antidepressants may need a gradual dose reduction (GDR) or tapering to avoid a withdrawal syndrome (examples: SSRI’s and TCA’s).

Contraindications for GDR

- The resident has a **psychiatric disorder** and use of the medication is within relevant standards of practice.
- MD has documented that GDR would impair function or cause psychiatric instability by exacerbating an **underlying psychiatric disorder**.
- Target symptoms returned or worsened after a GDR within the facility and the MD has documented a rationale for why an additional GDR at this time would impair function or worsen an **underlying psychiatric disorder**.
Depression: Standard of Practice
American Psychiatric Association

Other Psychiatric Conditions
• Conditions such as schizophrenia must be assessed and managed.

Medication Use and Monitoring
• Titrate dose based on age.
• Consider Treatment setting.
• Ability to tolerate therapy.
• If adverse medication events occur, lower dose or switch medication.

Response to Therapy
• Improvement should be seen within 4 to 8 weeks of starting treatment
• If there is no improvement after 8 weeks, reconsider the diagnosis.

Non-Chemical Interventions
• Psychotherapy sessions and focused cognitive behavior therapy should be provided while being treated with pharmacotherapy (depending on level of cognition).

Management of Partial Response
• An incomplete response to therapy is associated with poor functional outcomes.
• The acute phase of treatment should not be concluded prematurely in patients who do not fully respond.
• Frequency and approach to psychotherapy should be reassessed if there is poor response after 4 to 8 weeks.

Considerations for Medication Reduction
• To reduce risk of relapse, successful pharmacotherapy should be continued at the same dose for 4–9 months.
• Patients with 3 or more episodes of major depression or who have chronic major depressive disorder or who have ongoing residual symptoms should be considered for maintenance therapy.

Antipsychotic QAPI
Resident Population  Gradual Dose Reduction
True Psychiatric disorders  No Committee Oversight
Psychosis NOS Diagnosis  Psych consult w/ interventions
Undertreating Depression  Inadequate Staffing
Gradual Dose Reduction  Inadequate Training
Poor Documentation  Inappropriate Activities
Off-Label Prescribing  Facility Staff
High Use of Antipsychotic Agents

Undertreating Depression
Medical Director Approach

• Form a committee within the facility that will be responsible for regularly evaluating use of antipsychotics for dementia-related behaviors.
  – The committee should be interdisciplinary and include nurses and nursing assistants who are familiar with the resident, Social services, Consultant pharmacists, and others as appropriate
• A roster of residents should be assembled and scheduled for at least a quarterly review.

Medical Director Approach

• Format of the Resident Review
  – What is the person’s age, sex, marital and social status (who visits and how are behaviors before, during, and after those visits), military history, work history, and “fun” history
  – What were baseline target symptoms?
    • Were there psychotic symptoms such as delusions, paranoia, hallucinations?
    • Are there danger issues for other persons or property?
  – Medication with dose and frequency
    • Was medication treatment initiated at the facility?
    • What dose adjustments have been made with reason for change and response (include prior failed GDR attempt).

Medical Director Approach

• Format of the Resident Review
  – How did medication use correlate with non-pharmacologic interventions?
    • Specify what was used for each target symptom and what the response was.
  – MDS Data
    • BIMS
    • PHQ9
  – Medical Issues
    • Infection, Constipation, Pain, Weight Change, Pressure wounds or other skin issues, Changes in mobility, Use of medications with anticholinergic effect, changes in continence
  – How have behaviors responded to treatment?
Medical Director Approach

• Format of the Resident Review
  – If diagnosis is “Psychosis NOS”, what does that mean and how is it documented in the care plan?
• Treatment decisions
  – Any plan to reduce dose should be in context of what else is happening on the unit (example – other reductions that are happening) to reduce risk of potential chaos.
  – A plan for GDR should be tagged to a timeline for expected response and a “what if” plan
  – The plan does not necessarily have to wait for the psychiatrist, but at some point there should be psychiatric follow-up

Medical Director Assistance

Some Final Thoughts

• Where does facility stand with Health Care Proxies, Advance Directives, and Durable Powers of Attorney
  – MOLST
  – Palliative Care
  – Do Not Hospitalize Orders
  – Family Care Concerns
• Does the facility use the MDS or otherwise screen for changes in cognition and function with involvement of the medical staff.
• Does the facility engage in activities that promote brain health?
• Did we forget about polypharmacy?
LTC Staffing Crisis

• By 2020 there will be an across the board need for more nursing personnel.
  – 41% for RN’s
  – 47% for LPN’s
  – 50% for Nursing Assistants

• Studies show continued tendency toward turnover

LTC Staffing Crisis

"I hate my supervisor"
"I haven’t had a raise in 10 years"
"They changed health plans again?!"
"I get no respect"
"Take this 25 cent raise and shove it!"

"The benefits here are terrible"
"If they mandate me one more time"
"That D.O.N. is evil"
"I’m taking the job at the new place. They’re paying me 25 cents more per hour"

Increasing Job Satisfaction

• The Evidence Speaks
  – Professional growth opportunities
  – Adequate training
  – Reward performance
  – Manageable workload
  – Respect for knowledge and skills
  – Input in care planning
  – Sense that management trusts employees
  – Self-directed work teams
  – Career ladders
Top Needs of Employees

1. A manager who cares about them and values them.
2. Systems that work and the tools and equipment to do the job.
3. Opportunities for professional development.
4. Recognized and rewarded for doing a good job.
5. Don’t want to work with low performers.

Changing The Work Place

<table>
<thead>
<tr>
<th>Traditional</th>
<th>What about this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing to census</td>
<td>Steady staffing</td>
</tr>
<tr>
<td>Few benefits, if any</td>
<td>Affordable benefits</td>
</tr>
<tr>
<td>Sign-on bonus</td>
<td>Longevity bonus</td>
</tr>
<tr>
<td>Plug-in the hole</td>
<td>Take the time to hire right</td>
</tr>
<tr>
<td>Inadequate orientation</td>
<td>Thorough orientation</td>
</tr>
</tbody>
</table>

High Performers

- Tell them where the organization is going
- Thank them for their work and dedication
- Let them know why they are important to the success of the organization
- Ask if there is anything you can do for them
Middle Performers

• Let them know that you value them and want to retain them as employees
• Tell them why they are important to the organization
• Share one area for improvement and development
• Provide support and coaching

Low Performers

• Let them know what you have observed
• Let them know how you feel about what they have done
• Show them what needs to be done
• Let them know the consequences of low performance
• Be relentless in follow-up

Team Development

• Ask
  – What is working well?
  – Who should be recognized?
    • Reward those that are recognized by others as high performers
  – What tools and equipment are needed?
  – What systems are working?
  – Does anyone have any issues?
    • Record issues in a log book and resolve them
• Keep repeating the process
Maintain a Supportive Environment

- As leaders, reconnect with your passion for work.
- Never make excuses and don't tolerate them in your employees.
- Allow yourself to be vulnerable.
  - When you make a mistake, admit it
- Accept criticism graciously.
  - Don't take failure personally.
- Build a culture where it is OK to challenge leaders.
- When you issue challenges, do so publicly.
- Never punish someone for an honest mistake.

QUESTIONS?

Thank You for Your Attention