

The Nursing Home Quality Care Collaborative

44 of 76 facilities have signed on to the Collaborative as of February 1, 2013

- This initiative is designed to help you learn and develop Quality Assurance Performance Improvement techniques and plans before the final regulation is out.
- Learn from your peers within the state and from nationally recognized high performing facilities.
- I have heard that CMS expects facilities to have a QAPI program centered around the use of antipsychotic medication in residents with dementia.



Next Scholarship Opportunity

2013 Patient Safety & Quality
Improvement Conference:
Quality Improvement &
Medication Management: RX for
Patient Safety

2013 Patient Safety & Quality Improvement Conference: Quality Improvement & Medication Management: RX for Patient Safety

- Date April 4 & 5, 2013
- Riverside Hotel
- Registration is limited so sign up early
- Registration starts February 21, 2012
 - Qualis Health
- Available to Administrator, DON and Quality Assurance Director
- Scholarship will cover:
 - Registration fee
 - Hotel
 - Travel
 - Meals, not provided by the conference

Expected Outcomes

- reducing avoidable hospitalization and re-hospitalization of nursing home residents,
 - reducing unnecessary use of antipsychotics in residents with dementia, and
 - The expected final rule on QAPI.
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- Ensuring a safe medication process, including reconciliation, appropriate periodic review and gradual dose reduction are key to both avoiding hospitalization and quality dementia care. In addition nursing homes will be able to learn and apply quality improvement skills and tools they will need to be successful in compliance with QAPI

Changes to Survey Process

Details, Details and more Details in S&C Letter 12-45

What is old is new. We are back using data to drive pre-survey work.

QM reports are back and are used to identify possible areas of concern in a facility & potential residents.

Minimum sample to meet WPS-wt. loss, dehyd & PU

- Revised Questions for Administrator
 - A copy of the actual working schedule for licensed and registered nursing staff for all shifts during the survey period. This list may need to be revised during the course of the survey to reflect actual vs. planned work schedules.
 - A list of all residents who are or who have received antipsychotic medications over the past 30 days. (minimum of 4 on sample)
 - What individualized care and services are provided for residents with dementia?
 - How is staff trained to care for residents with dementia, including how to prevent or address the behavioral and psychological symptoms of dementia?

- How does the facility monitor the use of psychopharmacological medications, specifically antipsychotic medications?
- RHIT/RHIA: Need copy of AHIMA card
- Considerations for phase 2 of sample
 - Newly admitted or readmitted residents
 - Residents with no or infrequent visitors
 - Residents with psychosocial, interactive, and/or behavioral needs.
 - Residents who are bedfast & totally dependent on care
 - Residents receiving dialysis or hospice care .
 - Reviewing the care assessment areas (CAAs), looking for individualized care planning, awareness of quality of life needs.

Definitions

Short stay resident has a LOS of less than or equal to 100 days.

Long stay resident as a LOS of greater than 101 days.

ICF/IID Intermediate Care facility for individuals with intellectual disability (aka ICF/MR).



New info at F 441 re: Laundry & Infection Control

- Sent to administrators via e-mail 1/21/13
- Interpretative guidance has been updated to reflect changes in technology for cleaning agents and equipment.
- CMS in collaboration with CDC have determined that facilities may use any detergent designated for laundry in the laundry process.



- Must closely follow manufacturer's instructions for the product being used.
- Types of processing
 - Ozone systems
 - High temp 160° x 25 minutes
 - Low temp 71-77° + 125 ppm chlorine bleach rinse
 - Most common

- Not all laundry items can withstand the chlorine bleach rinse. The rinse is not required for items due to the new detergents available.
- So if you can get laundry items “hygienically clean” with detergent you do not need to use a bleach rinse.
- What is hygienically clean?
 - Free of pathogens in sufficient number to cause human illness.

Definition from the Association for the Advancement of Medical Instrumentation.



Suggestions & Monitoring

- Leave the washing machine open to dry out to avoid growth of microorganisms in wet and potentially warm environments.
- Staff must know and follow **ALL** manufactures instructions for all items/equipment involved in the laundry process.
 - washing machines dryers
 - laundry detergents rinse aide
 - ozone systems hot or low temp washing
- Follow manufactures instruction on how to produce a hygienically clean product.

F 155

Rights Regarding Advance Directives, Treatment, and Experimental Research

No change in regulatory language.

*Changes in surveyor guidance to help
determine compliance with the regulation.*

*The intent of this requirement is that the
facility promotes these rights by:*

- *Establishing, maintaining and implement
policies and procedures regarding these
rights;*

- Informing *and* educating the resident (family/responsible party) of these rights and the facility's policies regarding exercising these rights;
- Helping the resident to exercise these rights; and
- Incorporating the resident's choices regarding these rights into treatment, care and services.
- Ensuring staff follow policy and procedures

“Life-sustaining treatment” *is treatment that, based on reasonable medical judgment, sustains an individual’s life and without which the individual will die. The term includes both life-sustaining medications and interventions such as mechanical ventilation, kidney dialysis, and artificial hydration and nutrition. The term does not include medical procedures related to enhancing comfort or medical care provided to alleviate pain.*

Facility P&P

The facility is **required** to establish, maintain, and implement written policies and procedures regarding the resident's right to:

- Formulate an advance directive;
- Accept or refuse medical or surgical treatment; and
- Refuse to participate in experimental research

P&P continued

- Must delineate the various steps necessary to promote and implement these rights (there are many more identified on page 11-6 of the advanced copy)
 - Identifying the primary decision-maker (resident and/or legal representative);
 - Identifying situations where health care decision-making is needed; and
 - Establishing mechanisms for communicating the resident's choices to the interdisciplinary team

Advanced Directives

The facility must determine on admission if the resident has an advance directive. Examples of advance directives include:

- Living will
- Directive to the attending physician
- Durable power of attorney for health care
- Medical power of attorney
- Pre-existing physician's order for "do not resuscitate" (DNR)
- Portable order form re: life-sustaining treatment

Questions

- *Who should facilitate the conversation with the resident regarding advanced directives?*
- *Is there documentation of the conversation?*
 - *If yes, where is this documentation kept?*
- *Where should advance directives be kept?*

- *The facility is responsible for:*
- *Incorporating the information and discussions into the medical record; and*
- *Communicating the resident's wishes to the staff so that appropriate care may be provided.*
- *Identifying the primary decision maker*

Definitions

There are many more in the guidance

“Treatment” refers to interventions provided for purposes of maintaining/restoring health and well-being, improving functional level, or relieving symptoms.

“Legal representative”
is a person designated and authorized by an advance directive or by state law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.

a.k.a.

“Agent”

“Attorney in fact”

“Proxy”

“Substitute decision-maker”

“Surrogate decision-maker”

“Advance care planning”

is a process used to identify and update the resident’s preferences regarding care and treatment at a future time including a situation in which the resident subsequently lacks the capacity to do so; for example, when a situation arises in which life-sustaining treatments are a potential option for care and the resident is unable to make his or her choices known.

Advance Care Planning

is:

- An ongoing process that helps the resident exercise rights and make knowledgeable choices;
- A process by which the facility provides information to the resident or legal representative regarding: health status, treatment options, and expected outcomes; and
- A means by which resident choices are implemented and re-evaluated (both routinely and when the resident's condition changes significantly).

Right to Accept or Refuse Treatment

The facility is expected to:

- Determine what the resident is refusing;
- Assess reasons for the refusal;
- Advise about the consequences of refusal;
- Offer alternative treatments; and
- Continue to provide all other appropriate services

Investigative protocol

Will be applied to sample residents who

- *Have an advance directive or a condition where advance care planning is relevant;*
- *Have any orders related to provision of, life-sustaining treatments such as artificial nutrition/hydration, artificial ventilation, dialysis, blood transfusions, and cardiopulmonary resuscitation;*
- *Has refused treatment; or*
- *Is participating in an experimental research activity or project*

Compliance or Noncompliance

The list of possible noncompliance exceeds the list for compliance.

The facility is **in compliance** if the facility has:

- Incorporated the resident's choices into the medical record and orders related to treatment, care and services; and
- Monitored the care and services given the resident to ensure that they were consistent with the resident's documented choices and goals

Noncompliance include, but is not limited to, failure to do one or more of the following:

- *Establish and implement policies and procedures regarding the right to establish advance directives, to decline treatment and other related interventions, and to decline to participate in experimental research;*
- *Inform and educate the resident about these rights, including the facility's policies regarding exercising these rights;*
- *Determine whether the resident has an advance directive in place or offer the resident the opportunity to formulate an advance directive; Help the resident exercise these rights based on determining the capacity of the resident to understand information and make treatment decisions or through the input of the identified legal representative of the resident who lacks sufficient decision-making capacity;*

- *Incorporate the resident's choices into decisions and orders related to treatment, care, and services;*
- *Help the resident exercise these rights based on determining the capacity of the resident to understand information and make treatment decisions or through the input of the identified legal representative of the resident who lacks sufficient decision-making capacity;*
- *Incorporate the resident's choices into decisions and orders related to treatment, care, and services;*

Suggestions

- Review current policy and procedures to ensure they include all required elements. May want to include corporate &/or legal folks.
- Ensure the staff who are talking with residents understand the policy and procedures. You may want to evaluate who is conducting this interview with residents.
- Review the advanced directive status at each quarterly care planning conference.
- Consider the timing/scheduling of care conference to facilitate family participation.
- Ensure the discussions are documented and retained in the clinical record.
- Periodically conduct the investigative protocol to ensure there has not been a break in policy and procedures.

General Info

- QIS implementation remains unknown
- 2012 IDR stats
 - 2 facilities
 - 3 tags all upheld
 - 314 & 323 & 325
- 2012 IIDR stats
 - 1 citations upheld

Stuff and Stuff

- Surveyors will be using tablets.
- You will see lots of new faces, new LTC survey staff and staff who are primarily assigned to the ICF/IID program.
- Security change MDS submission effective 3/29/13. You will no longer be able to access the internet, network printers or network folders while connected to CMS.
- Insulin Pens
 - containing multiple doses of insulin must never be used for more than one person, even when the needle is changed.
 - must be clearly labeled the resident's name or other identifiers to verify that the correct pen is used on the correct resident.
 - review your policies and procedures and ensure staff are trained regarding safe use of insulin pens





More Stuff

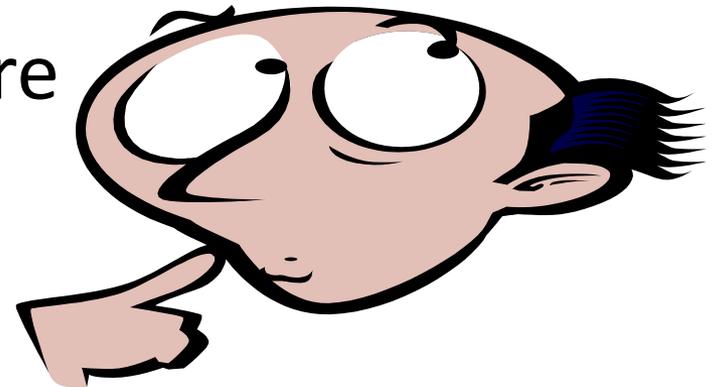
- 3 most frequent meds cited for black box
 - Zyprexa
 - Seroquel
 - Risperdal
 - These three drugs are not approved for treatment of patients with dementia related psychosis.
- Annual application questions: SW and RHIT.
- Revised guidance relies heavily on social services and clinical documentation.
- Crowded dining rooms – having to move one resident so another one can get in or out

Top 2 G level citations

- ?
- F314 cited 11 times since August
- F323 (falls) cited 15 times since August

Abuse how do you handle?

- Family yelling at a resident
- Family throwing things at a resident
- Family slapping a resident
- A resident who is “out of control” causing other residents to be fearful.
- Last calendar year there were 1200 call to the hot line.



Hand in Hand Training Videos

The Affordable Care Act: (Section 6121) requires that nurse aides receive regular training on how to care for residents with dementia and on preventing abuse. CMS created this training program to address the requirement for annual nurse aide training on these important topics.

Facilities are **not** required to use Hand in Hand specifically as a training tool. Other tools and resources are also available.



FLS&C

- Evaluating every door in the facility for closure, locks and paths of egress. We are finding locked units we were not notified of, and blocked exits.
- Make sure all exits are free from ice and snow.
- Fire watch if sprinkler system is down for greater than 4 hours.
- Report power outages of greater than 4 hours.

F 309 Quality of Care

Has been revised again to include End of Life concerns.

Dove tails very closely with the new guidance at F 155.

Imminently dying-- indicates death is anticipated within hours to a week or two at most, because there are no treatments or interventions to prolong life or because the resident has declined to undergo treatment that could potentially prolong life.

Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

- The goal of palliative care is to relieve suffering and provide the best possible quality of life for the resident and his or her family.

Palliative care focuses on symptom relief and comfort, but does not necessarily limit diagnostic, preventative or curative interventions.

It is expected that the facility including the medical director, develop, implement and modify policies and procedures :

- To identify
- Assess
- Manage potential palliative care conditions and
- That they are consistent with current standards of practice.

Care Planning/Coordinated Plan of Care for a Resident approaching End of Life

When the resident is nearing the end of life, it is important that the physician and interdisciplinary team review or update the prognosis with the resident and/or the resident's legal representative and review and revise the care plan as necessary to address the resident's situation.

When hospice services are involved, the facility and hospice are jointly responsible for developing a coordinated plan of care for the resident that guides both providers and is based upon their assessments and the resident's needs and goals.

Coordination with Hospice

- Each provider retains responsibility for care in accordance with their respective regulations.
- The SNF must provide the same care to a resident who has elected hospice as any other resident, i.e. baths, assistance with eating, medication administration.

Investigative Protocol

- Will be used when a resident is identified as
 - Receiving end of life care, hospice services, palliative care, comfort care or terminal care.
 - Whose diagnoses, assessment, and/or care plan indicated that the resident may be approaching end of life.

Questions/Thoughts/Comments

- Are your policy and procedures current in that they provide enough direction to staff on end of life?
- What is comfort care?
- Does the facility have a definition for comfort care? Does the medical director and medical staff agree?

F 322

- Collapsed F 321 guidance into F 322
- NG tube = any feeding tube which provides enteral nutrition.
- Added lots of definitions:

• Avoidable	Unavoidable	Bolus
• Continues	Enteral nutrition	
• Feeding tube	G-tube	J-tube
• NG tube	G-J tube	tube feeding

Intent

1. Ensure it is medically necessary
2. Utilized in accordance with current clinical standards.
3. Services are provided to prevent complications to the extent possible.
4. Services are provided to restore normal eating skills to the extent possible.

Resident is admitted with a tube

- The IDT reviews the basis for initial placement.
- The resident's current conditions is assessed.
 - Is there a continued rational for the tube &
 - Is the continued use consistent with the resident's treatment, goals and wishes. (F155)
- Decisions to continue or discontinue the use of a feeding tube:
 - Are collaborative and involve the resident (or legal representative), physician and interdisciplinary team;

Policy and Procedures

aka Technical Aspects

Require Medical Director involvement

Must address:

- Location of the feeding tube
- Care of the feeding tube
- Feeding tube replacement
- The nutritional aspects of feeding tubes
- Enteral nutrition
- Flow of the feeding
- Potential complications related to the Feeding tube
- Complications related to the Administration of the Enteral Nutrition product.
- Complications Management

Location of the Tube

- How staff are to monitor, and \checkmark placement
- How staff are to verify placement before starting the feeding or administering medication.
- The frequency staff should monitor that the tube is secured appropriately and the skin is intact.

Care of the feeding tube

- How are staff to secure the feeding tube externally?
- Infection Control precautions
- How frequently, and how much is used for flushing the tube.
- Examination and cleaning of the insertion site

Feeding tube replacement

1. When to replace or change a feeding tube
2. How and when to check for splits or cracks
3. Situations when the tube can be replaced in the facility and by whom
4. Situations when the tube must be replaced in another setting, such as ASC or hospital
5. Practitioner notification when a change is needed unexpectedly.

Orders

Must include:

1. Kind of feeding and its caloric value
2. Volume
3. Duration
4. Mechanism of administration (gravity or pump)
 - frequency of calibration of the pump
 - Maintenance of the pump per manufactures instructions.
5. Frequency and volume of flush

Significant Complications Related to the Feeding Tube

Aspiration

Leakage around the insertion site

Stomach or Intestinal perforation

Abdominal wall abscess

Erosion at the insertion site (including nasal area)

Esophageal Complications Related to the Feeding Tube

- Peritonitis
- Esophagitis
- Ulcerations
- Strictures
- Tracheoesophageal fistulas
- Clogged tube

Complications Related to the Administration of the Enteral Nutrition Product

- Nausea;
- Vomiting;
- Diarrhea;
- Abdominal cramping;
- Inadequate nutrition;
- Aspiration;
- Reduced effectiveness of various medications; or
- Metabolic complications

Aspiration

- Can be dependent on other risk factors;
- Is not necessarily related to gastric residual volumes; and
- Should be assessed individually to implement interventions accordingly (e.g., positioning).

Enteral Formula May Reduce the Effectiveness of Some Medications

For example: The effectiveness of Dilantin may be reduced by the drug binding with the enteral feeding's protein component, leading to less free drug availability and possibly inadequate therapeutic levels.

Make sure your pharmacist is aware if you are administering the medication via the tube and with the enteral product.

Metabolic Complications

Metabolic complications related to tube feeding may include inadequate calorie or protein intake, altered hydration, hypo- or hyperglycemia, and altered electrolyte and nutrient levels.

Complications Management

The facility is expected to:

- Identify and address actual or potential complications related to the feeding tube or tube feeding; and
- Notify and involve the practitioner in evaluating and managing care to address these complications and risk factors.

Who should be involved resident's with tube feedings?

Social Worker

Pharmacist

Registered Dietitian

Physician

Nursing

Resident

Anyone else????

