

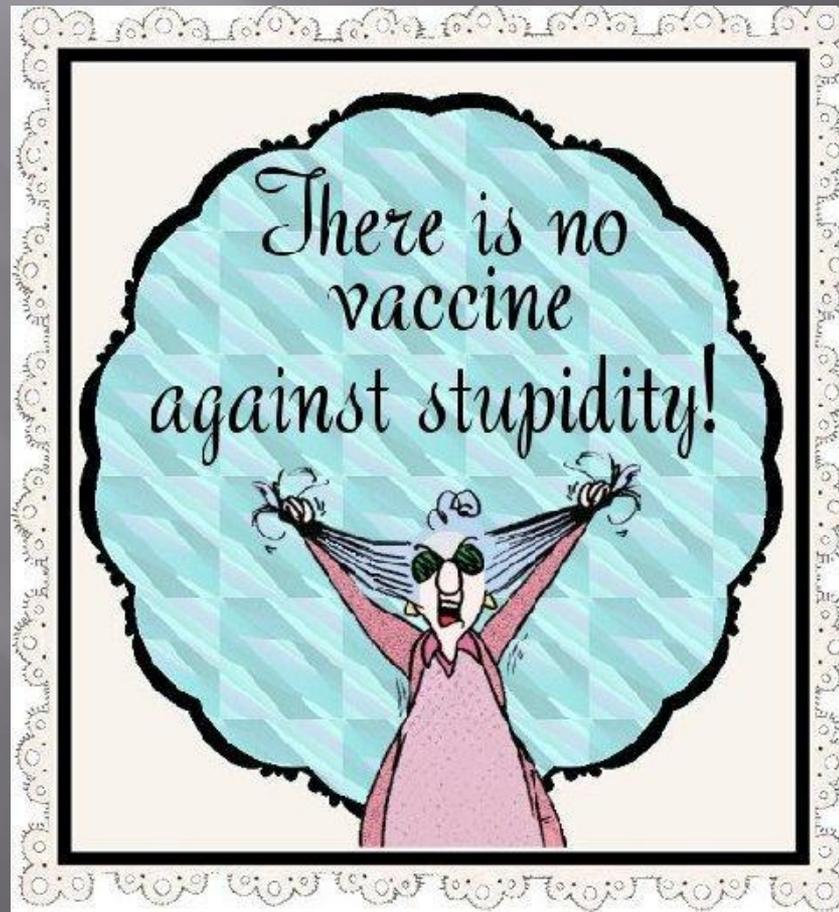


MEDICAL ERRORS

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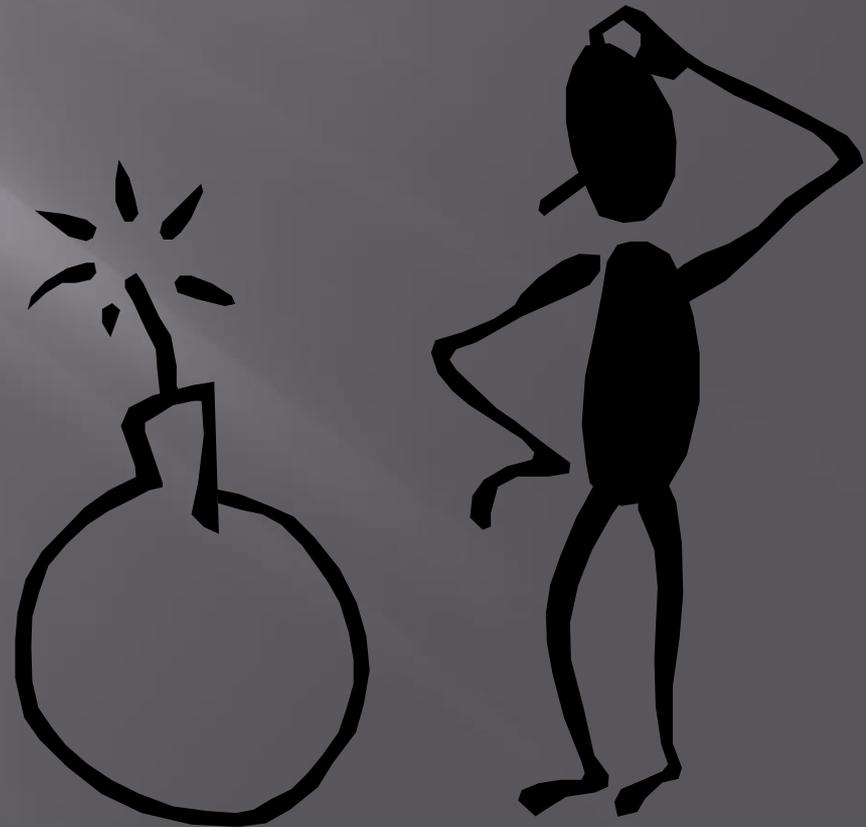


Professional Disclaimer

- ▣ I have no real or perceived conflicts of interest with any pharmaceuticals, or other companies.
- ▣ I am not being paid or compensated by any other organization for the following presentation.
- ▣ I will not be making any prescribing recommendations of any kind or endorsing any products.

▣ **Let's begin.....**

▣ Think of your life.....your kids,
parents, spouses, friends and
pets.....



Objectives



"...and this is Ralph, your anesthesiologist."

- Summarize types of medical errors.
- List factors that increase risk for medical errors.
- Commonly missed diagnosed medical errors.
- Root Cause Analysis.
- Define populations of increased vulnerability.
- Identify Mandates for reporting medical errors
- Improving patient outcomes.... error reduction
- Discuss public education measures related to patient safety and caretaker involvement.

Why Learn About Medical Errors

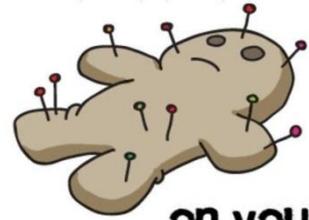
- ❑ Medical errors injure 1 in every 25 hospital patients and is responsible for tens of thousands of deaths each year.
- ❑ Medical errors are more deadly than breast cancer, motor vehicle accidents, or AIDS.
- ❑ Medical errors cost the economy as much as \$29 billion each year (IOM, 1999).

The pain will
go away when it
stops hurting.

- ❑ 1 in 3 people who enter a U.S. hospital will experience an adverse event (an injury or illness from a medical error) (Classen et al., 2011).
- ❑ Every week in the United States there are forty wrong-site or wrong-patient surgeries performed (Dentzer, 2011).
- ❑ In 2008, nearly 2 million people were harmed by adverse drug events (medication side effects or the wrong type or wrong dose of medication) (AHRQ, 2011a).
- ❑ In Florida, 168 patients died in 2010 and another 386 were victims of serious mishaps, including medication errors, wrong-site surgeries, and foreign objects such as tools or sponges left behind after operations (*Sun Sentinel*, 2011).

□ Travel through one patient's life and the medical errors they experienced are they all catastrophic or even bad?.....

don't make me
do voodoo...



on you.



Simple Stupid? People still don't do it right!!.....

- ▣ The United States Centers for Disease Control (CDC) reports that “handwashing is the single most important means of preventing the spread of infection”.



Excuses For Poor Hygiene

- ❑ Hand washing agents cause irritation and dryness
- ❑ Sinks are inconveniently located/lack of sinks
- ❑ Lack of soap and/or paper towels
- ❑ Too busy
- ❑ They don't "look" dirty!
- ❑ "I was wearing gloves"



What to DO...

- ▣ Perform hand hygiene after contact with blood, bodily fluids, secretions, and non intact skin.
- ▣ Wear disposable gloves when contact with infectious blood or bodily fluids is anticipated.
- ▣ Wash hands after the use of gloves.

In Preop.....



BUSTED

You know what you did.

In 2007 the federal Center for Medicare and Medicaid Services issued a new rule that gave hospitals a powerful incentive to reduce medical errors: this rule denies reimbursement to hospitals for treatment of preventable errors, injuries, and infections. It also stipulates that hospitals cannot pass these charges along to the beneficiary.

The following preventable complications will no longer be reimbursed by Medicare if acquired during an inpatient stay:

- ▣ • Object left in patient during surgery
- ▣ • Air embolism
- ▣ • Blood incompatibility
- ▣ • Catheter-associated urinary tract infection
- ▣ • Pressure ulcer
- ▣ • Vascular catheter-associated infection
- ▣ • Mediastinitis after coronary artery bypass grafting
- ▣ • Fall from bed
- ▣ Source: Federal Register 2007; 72:47379-47428.



Types of Medical Errors

- ▣ Adverse Event (AE)- an injury caused by medical management rather than the underlying condition of the patient, also called a sentinel event
- ▣ Active Error- errors made by an individual
- ▣ Latent Error- errors in system or process design, faulty installation or maintenance of equipment, or ineffective organizational structure
- ▣ Potential Adverse Events- “near misses” and “close calls”, errors that could have caused harm but did not



Most Common Errors

- While wrong site/ wrong procedure surgery continues to be the most common basis for quality of care violations, the following areas have been determined by the Board of Medicine as the five most mis-diagnosed conditions as demonstrated by disciplinary cases:
 - Cancer
 - Cardiac
 - Acute abdomen
 - Timely diagnosis of surgical complications
 - Failing to identify pregnancy or stage of pregnancy before beginning treatment or surgery

- ❑ Adverse Drug Event (ADE)- errors caused by the miss administration of medications
- ❑ Surgical Adverse Events- include wrong-site, wrong-procedure, or wrong-person surgery and account for a high percentage of all AEs. A study of hospitals in Colorado and Utah found that surgical AEs accounted for two-thirds of all AEs and 1 of 8 hospital deaths (Gawande et al., 1999).
- ❑ Inaccurate Diagnosing- attributing the wrong diagnosis to a patient



- ▣ Problems with Medical Equipment-
In 1990, Congress passed the Safe Medical Devices Act (SMDA), which requires that designs be "appropriate and address the intended use of the device, including the needs of the user and patient." The application of human factors principles during a device's design has been demonstrated to reduce user error (Making Healthcare Safer, 2001).

- Practice Errors- •Causing physical harm to the patients
- •Delaying patient discharge
- •Creating unrealistic treatment and/or prognosis expectations
- •Providing unneeded services
- •Failure to provide needed services (Scheirton et al., 2003)
- •Psychosocial errors
 - o Showing lack of confidence in front of a patient
 - o Withholding information about a patient's prognosis
- •Lack of needed equipment
- •Incorrect equipment installation
- •Poor equipment design
- •Wrong or unclear physician orders
- •Unclear, insufficient or illegible documentation
- •Communication breakdown among service providers
- •Productivity pressure
- •Lack of experience (Scheirton et al., 2003)

Factors that Increase Error

- ▣ Fatigue
- ▣ Drugs/Alcohol
- ▣ Illness
- ▣ Inattention/Distraction
- ▣ Emotional State
- ▣ Unfamiliar Situation/Problem
- ▣ Equipment Design Flaws
- ▣ Communication Problems
- ▣ Hard to read handwriting
- ▣ Unsafe Working Conditions
- ▣ Inadequate Labeling/Instruction



Root Cause Analysis

- ▣ Root cause analysis (RCA) is a widely adopted method of identifying underlying causes of medical error. An effective RCA looks beyond the immediate result and identifies the chain of events or contributing factors which led to the error. It uses a structured and process-focused framework to analyze errors to identify what happened, why it occurred, and what can be done to prevent recurrence. The process looks at both active and latent errors and avoids the tendency of assigning individual blame. Active errors are described as those acts or omissions which are committed by the people in direct contact with the patient. Examples of active errors include administering the wrong medication, deviating from safe operating practices, or cognitive failures such as memory lapses leading to patient injury. Latent errors are those failures which are removed from the direct control of the front line caregiver. Examples of latent errors are those caused by inordinate time pressures, inadequate staff, or equipment failures. A root cause analysis must be credible and thorough to be effective. The factors necessary for both elements are described in the table on the next page.

☐ **CREDIBLE & THOROUGH**

- ☐ **Multi-disciplinary team** - The review team is comprised of participants from multiple disciplines and backgrounds closely associated with the processes and systems being reviewed. **Identification of all proximate causes** - Proximate causes are those events or occurrences which produce an effect or result. They are the catalyst from which anything proceeds and without which, it would not exist. All of the proximate causes must be identified and considered.
- ☐ **Team training** - Necessary training is provided team members. **Review of all related systems and processes** - A review of all of the related or involved systems and processes must be completed. Inherent in this review should be direct inquiry as to “why” all of the steps in the process are done or not done.
- ☐ **Consideration of all influences** -Consideration is given to all of the systems and processes that were involved in the event. None of the involved systems and processes can be ignored or left untouched. **A continuous focus on all opportunities to improve systems** - Attention must be given to any opportunities for corrective actions. All opportunities for improvement must be addressed.
- ☐ **Review of all pertinent literature** – Relevant literature and written material on the processes and systems are included in the review process. **Plan outline** – An outline of the planned recommendations must be provided which addresses the opportunities for improvement as well as explaining those situations where opportunities are not being pursued.
- ☐ **Team endorsement** – The team’s findings are consistent and provide conclusions which do not raise questions or contain contradictory information. Additionally, the recommendations should be endorsed by the entire team. **Plan explanation** – The recommendations arising out of the review process should be explained fully, including the assignment of responsibility to specific individuals and a methodology for measuring outcomes and results.
- ☐ **Administrative support** – The findings of the review team should be supported and endorsed by the administration. Copies of the recommendations should be made available to all personnel who could benefit from them.

- ▣ The goal of a root cause analysis (RCA) is to find out:
- ▣ What happened
- ▣ Why it happened
- ▣ What to do to prevent it from happening again
- ▣ Root cause analysis is:
- ▣ Interdisciplinary, involving experts from the frontline services
- ▣ Involving of those who are the most familiar with the situation
- ▣ Continually digging deeper by asking “why, why, why” at each level of cause and effect
- ▣ A process that identifies changes that need to be made to systems
- ▣ A process that is as impartial as possible
- ▣ To be **thorough**, an RCA must include:
- ▣ Determination of human and other factors
- ▣ Determination of related processes and systems
- ▣ Analysis of underlying cause-and-effect systems through a series of *why* questions
- ▣ Identification of risks and their potential contributions
- ▣ Determination of potential improvement in processes or systems
- ▣ To be **credible**, an RCA must:
- ▣ Include participation by the leadership of the organization and those most closely involved in the processes and systems
- ▣ Be internally consistent
- ▣ Include consideration of relevant literature (U.S. Dept. Veterans Affairs, 2009a)

Populations of Particular Vulnerability

The safety of all patients is of paramount concern for all care providers. However, some patients – for example, the very young and the very old – are particularly vulnerable to the effects of medical errors, often due to their inability to participate actively as a member of the healthcare team, most commonly related to communication issues. Nurses and other care providers need to recognize the special needs of these patients and act accordingly.

Older Patients

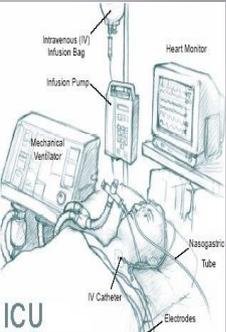


- ❑ Often have hearing, vision, and some degree of cognitive impairment
- ❑ Are at special risk for medication errors
- ❑ Are at a higher risk of falls
- ❑ Often need extra assistance
- ❑ When caring for older patients, communication with a responsible family member or other patient advocate is essential.



Infants and Children

- ❑ Greater risk of medication errors with digestive complications
- ❑ Parents/guardians should know a child's weight in kilograms, and check dosing with a doctor
- ❑ Do not have all the necessary communication skills so it is essential to communicate with the parents/guardians
- ❑ One research study in two urban teaching hospitals found that errors occurred in 5.7 percent of medication orders during the care of 1,120 pediatric patients admitted during 1999 (Kaushal et al., 2001). In addition, the rate of potential ADEs (close calls or near misses) was three times the rate of potential ADEs found in a similar study of hospitalized adults.



Patients in Intensive Care

- A decade ago, Israeli scientists published a study in which engineers observed patient care in ICUs for twenty-four-hour stretches. They found that the average patient required 178 individual actions per day, ranging from administering a drug to suctioning the lungs, and every one of them posed risks.
 - – ATUL GAWANDE, 2007
 - ICU patients are far more prone to medical error and injury due to their delicate conditions
 - Because of the complexity of these cases the basics are often over looked

Some particularly prevalent problems among ICU patients include:

▣ **Tubing Misconnections :**

- Wrong delivery route: transposition of IV and epidural lines
- IV fluid infused into bladder, pulmonary, or dialysis lines
- Breast milk or formula infused into infant IV lines



RECOMMENDATIONS TO REDUCE TUBE MISCONNECTIONS

- Do not purchase non-intravenous equipment that is equipped with connectors that can physically mate with a female luer IV line connector.
- Conduct acceptance testing (for performance, safety, and usability) and, as appropriate, risk assessment (eg., failure mode and effect analysis) on new tubing and catheter purchases to identify the potential for misconnections and take appropriate preventive measures.
- Always trace a tube or catheter from the patient to the point of origin before connecting any new device or infusion.
- Recheck connections and trace all patient tubes and catheters to their source upon the patient's arrival to a new setting or service as part of the hand-off process. Standardize this "line reconciliation" process.
- Route tubes and catheters having different purposes in different, standardized directions (eg., IV lines routed toward the head; enteric lines toward the feet). This is especially important in the care of neonates.
- Inform non-clinical staff, patients and their families that they must get help from clinical staff whenever there is a real or perceived need to connect or disconnect devices or infusions.
- For certain high-risk catheters (eg., epidural, intrathecal, arterial), label the catheter and do not use catheters that have injection ports.
- Never use a standard luer syringe for oral medications or enteric feedings.
- Emphasize the risk of tubing misconnections in orientation and training curricula.
- Identify and manage conditions and practices that may contribute to healthcare worker fatigue, and take appropriate action.

- ▣ Catheter Related Infections : Central venous catheter-related bloodstream infections are not only potentially fatal but also cost the healthcare system an estimated \$2.3 billion each year (O'Grady, 2002).
- ▣ Respiratory Complications : Patients on ventilators are prone to bacterial pneumonia as well as development of stomach ulcers. Resar and colleagues (2005) found that use of a checklist that included a "bundle" of evidence-based care processes,* such as propping up the patient's bed at least 30 degrees (to prevent aspiration of oral secretions) and administering antacid medications (to prevent stomach ulcers), reduced the incidence of pneumonias in ventilator patients by one-fourth and reduced length of stay in ICU by one half.

- ▣ Literacy : When literacy collides with healthcare, the issue of "health literacy"* begins to cast a long patient safety shadow.
—JCAHO, 2007, "What did the doctor say?"
- This includes Health Literacy (the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions)



Fall Risk and Prevention

▣ FACTORS THAT INCREASE RISK FOR FALLS

- Age 65 or over
- History of falling
- Impaired mobility or difficulty walking
- Need for assistance in getting out of bed or transferring to/from chair
- History of dizziness or seizures
- Impaired vision, hearing, or speech
- Need for mobility-assistive devices (cane, walker, wheelchair, crutches or braces)
- Weakness or fatigue
- Confusion, disorientation, impaired cognitive function
- Use of medications such as diuretics, laxatives, or consciousness-altering drugs including sedatives, analgesics, hypnotics, antidepressants, tranquilizers.



Some common ways to prevent falls from occurring include:

- ▣ Physical Restraints
- ▣ Bed Alarms
- ▣ Special Flooring
- ▣ Bedrails
- ▣ Hip Protectors



Practicing Medication Safety

- ▣ **Follow the six “rights”**
 1. right patient
 2. right drug
 3. right dosage
 4. right dosage form
 5. right time
 6. right route



Medication Errors- •

Omission errors (failure to administer an ordered medication dose)

• **Improper dose/quantity errors** (any medication dose, strength, or quantity that differs from that prescribed)

• **Unauthorized drug errors** (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug

System Failure- "Most systems and most individuals resist change. Systems must have substantial inertia to make them stable, and medicine is no exception. In many ways, medicine is still a "cottage industry" of individuals (both clinical and administrative) who do things their own way, in their own silos."

(Pauker et al., 2005)



- Medication errors are one of the most common types of error and are of primary concern to those who prescribe, dispense, and administer them as well as to providers who work closely with medicated patients. A large international study found that poor coordination of care is a key risk factor for medication errors. Researchers cited the expressed need for “better communication among multiple healthcare providers and more structured organization of care across healthcare settings” (Lu & Roughead, 2011).
- Medication errors are considered preventable **adverse drug events (ADEs)**. According to the IOM (2006), medication errors occur most frequently in prescribing and administering. These errors include:
 - **Omission errors** (failure to administer an ordered medication dose)
 - **Improper dose/quantity errors** (any medication dose, strength, or quantity that differs from that prescribed)
 - **Unauthorized drug errors** (the medication dispensed and/or administered was not authorized by the prescriber); this category includes dispensing or administering the wrong drug

Patients can:

- Tell physicians about all medications they are taking and responses/reactions to them.
- Tell physicians about any change in their health since the previous visit.
- Ask for information in terms they understand before accepting medications.
- Insist that the physician include the purpose of the medication on the prescription.
- Check to be sure a refill is what it's supposed to be.

Providing organizations and practitioners can:

- Educate patients.
- Put allergies and medications on patient records.
- Stress dose adjustment in children and older persons.
- Limit access to high-hazard drugs.
- Use protocols for high-hazard drugs.
- Computerize drug order entry.
- Use pharmacy-based IV and drug mixing programs.
- Avoid abbreviations.
- Standardize drug packaging, labeling, storage.
- Use "unit dose" drug systems (packaged and labeled in standard patient doses).

Purchasers can:

- Require machine-readable labeling (barcoding).
- Buy drugs with prominent display of name, strength, warnings.
- Buy "unit of use" packaging ("unit dose").
- Buy IV solutions with two-sided labeling.

To reduce the potential for taking a medication that was not prescribed for them or cannot be safely taken by them, patients should ask the following questions before accepting prescription drugs:

- Is this the drug my doctor (or other healthcare provider) ordered? What is the trade and generic name of the medication?
- What is the drug for? What is it supposed to do?
- How and when am I supposed to take it and for how long?
- What are the likely side effects? What do I do if they occur?
- Is this medication safe to take with other over-the-counter or prescription medications, or dietary supplements, that I am already taking? What food, drink, activities, dietary supplements or other medication should be avoided while taking this medication?

ISSUES RELATED TO MEDICATIONS IN PT/OT SETTINGS

Setting	Issues	Common Medications
Pediatrics	<p>Family education and issues related to pediatric dosing are common problems.</p>	<ul style="list-style-type: none"> • anti-spasticity • seizure • cardiac • pain • chemotherapy medications
Geriatrics and Home Health	<ul style="list-style-type: none"> • Under-medication and over-medication are both common, as are issues related to geriatric dosing. • Loss of muscle mass and body fat can significantly alter the absorption and metabolism of many common medications. • Poor communication can affect whether a medication is given or withheld. • Change of condition or transfer to a new setting can result in abrupt medication changes. • Polypharmacy can lead to adverse events such as falls. • Laxatives and stool softeners may affect activity levels. • Alcohol and recreational drugs may cause balance problems, swallowing problems and weakness. • Medications may be stopped or not taken as prescribed due to cost or inability to get to the pharmacy. • Over-the-counter (OTC) medications may be mixed with prescription medications. • Anticholinesterase drugs may cause fatigue, especially in people with disorders that affect muscle strength, such as post-polio syndrome. 	<ul style="list-style-type: none"> • cardiac medications • antidepressants • narcotics • OTC medications • alcohol • recreational drugs • anticoagulants • laxatives • stool softeners • anticholinesterase drugs • cough medicines and expectorants • antihistamines • allergy and motion sickness drugs
Outpatient	<ul style="list-style-type: none"> • Herbal medication interacting with prescribed medications • Drug and alcohol abuse, recreational drugs • Overuse of pain and anti-inflammatory medications • Performance-enhancing drugs used by athletes can have a variety of physical effects. • Non-narcotic analgesics and OTC medications can cause drowsiness, weakness and fatigue and can mask the effects of overtraining. 	<ul style="list-style-type: none"> • anti-inflammatories • narcotics • steroids • herbal medications • alcohol • recreational drugs • antidepressants

□ High Risk/High Alert Medication :

- Limit access. When possible, dispense neuromuscular blocking agents from the pharmacy as prescribed for patients. Allow floor stock of these agents only in the OR, ED, and critical care units where patients can be properly ventilated and monitored.
- Segregate storage. When these agents must be available as floor stock, have the pharmacy assemble the vials in a sealed box with warnings affixed as noted below. Sequester the boxes in both refrigerated and nonrefrigerated locations.
- Warning labels. Affix fluorescent red labels that note: "Warning: Paralyzing Agent-Causes Respiratory Arrest" on each vial, syringe, bag, and storage box of neuromuscular blocking agents. Commercially available labels can be purchased from United Ad Label Co. Call 1-800-992-5755 and order item #AM282. (ISMP, 2005)

□ Computerized Physician Order Entry : automates the medication ordering process

- Systems-based analysis of medication errors and ADEs suggest that changes in the medication ordering system, including the introduction of computerized physician order entry (CPOE) with clinical decision support systems (CDSSs), may reduce medication-related errors (Making Healthcare Safer, 2001).



PREVENTING ERRORS IN PATIENT-CONTROLLED ANALGESIA (PCA)

- Include bar codes on all PCA medications in facilities where point-of-care bar code systems or other item identification technology (eg., radio frequency identification) are implemented.
- Conduct a failure modes and effects analysis (FMEA) for existing pumps, as well as for new pumps that are brought into the facility. Consider what default settings are preprogrammed. Consider if the pumps can be programmed by drug (eg., morphine PCA vs. hydromorphone PCA). Consider if the pump resets to a default (other than "000," which would require active entry) after it turns off.
- Perform double-checks for initial setup and maintenance, and dose changes/change orders. Double-check clamp (to open position) before closing the pump. Check that the pump is turned on. Check whether connections are to IV or epidural lines to prevent wrong-route errors. Check for kinked tubing in the pump door.
- Educate staff about sound-alike and look-alike drugs, especially when bar code technology is not part of the existing system. Many drug errors with PCA pumps are due to name confusion (eg., morphine, hydromorphone, meperidine).
- If using preprinted order forms, prohibit writing over information on the form.
- Educate patients, family members, and staff (including physical therapists, x-ray technicians) about the use of the pumps. Written instructions should be provided to patients. Instruct family members NOT to administer PCA doses—PCA by definition should be administered at the patient's perception of need. Document education of patient and family members.

- ▣ **Medications in Non-Healthcare Settings**
- ▣ Recommendations includes proper storage, written policies and procedures, limitations on the type of medications stored by the organization, training programs, safeguards to prevent theft of controlled medications, and reporting and evaluation of medical errors. (See <http://www.nccmerp.org/councilRecs.html> for more information.)



Documentation

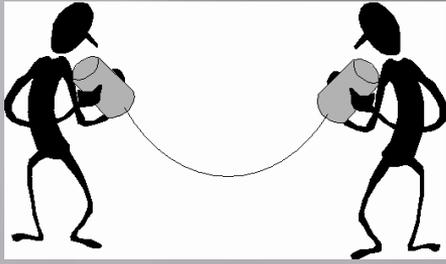
If a practice error occurs, especially if it results in a lawsuit, good documentation is essential. In Reporting Risk Check-Up, Susan Abeln makes several key points about documentation:

- The documentation must be rendered accurately and clearly reflect the patient's condition, the care rendered to the patient and the patient's progress.
- Each care provider's documentation must be consistent with his or her own practices; the documentation of all providers in a department or clinic must be consistent.
- In general, more objective information in the record is better, assuming that everything included is factual and understandable.
- In all reporting, especially electronic reporting, confidentiality must be maintained and modifications in the record must be fully explained. (Abeln, 1999)

DOCUMENTATION CHECKLIST

- Document in the correct chart.
- Document any prevention measures including patient education.
- Write legibly, using agency-approved abbreviations.
- State the facts, not vague feelings.
- Be objective. Do not document personal opinions like "The patient is crazy" or "The patient seems angry."
- If you identify a problem, document the actions you took to address the problem.
- Document all communication with your colleagues encourage them to document what they report to you.
- Document only what you see, hear, feel, or smell.
- Document errors and how you dealt with the error.
- Document referrals to other health practitioners or services.
- If you document a patient symptom or complaint, also document what actions you took to address the problem.
- Never alter a patient record; follow your agency procedures for correcting a charting error.
- Document in a timely manner throughout your shift rather than waiting until the end of your shift.
- Do not pre-chart.
- Never document what someone else saw or heard unless the information is critical, in which case make attribute the information within quotes.





Communication

- Electronic medical records (EMRs) and other information technology can improve communication and patient safety if fully implemented in hospitals and other healthcare facilities. For example, EMRs can help reduce medication errors, avoid the need to repeat laboratory tests, and improve continuity of care across the healthcare system. All healthcare providers within a system have access to accurate and complete information when they need it.

- **Patients with Limited English and/or Limited Health Literacy**
- Meeting the healthcare needs of Florida's culturally and ethnically diverse population may require bilingual care providers, translators or interpreters, or other communication experts. Without these experts available, **miscommunication** of vital information between patient and provider can lead to misunderstanding and errors.
- Many facilities have translators or interpreters available for patients who do not speak English. If translation assistance is not available, communicating with a family member or other support person is essential. It is important to keep words simple and concrete and to use pictures or diagrams to explain procedures.
- Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. A U.S. Department of Education (2006) assessment found that more than one third of the U.S. population has only basic or below **basic health literacy**.



Big egos are
big shields
for lots of www.bit.ly/positiveoutlooks
empty space.

- by Diana Black

Reporting Errors

Joint Commission Error Reporting : • Have a process in place to recognize sentinel events

- Conduct thorough and credible root cause analyses that focus on process and system factors, not on individual blame
- Document a risk-reduction strategy and internal corrective action plan within 45 days of the organization becoming aware of the sentinel event

Root Cause Analysis (RCA) : • What happened

- Why it happened
- What to do to prevent it from happening again

Beyond Blame

The medical imperative is clear: to make health care safe we need to redesign our systems to make errors difficult to commit, and create a culture in which the existence of risk is acknowledged and injury prevention is recognized as everyone's responsibility.

—LEAPE ET AL., 1998



Culture of Safety :•

Acknowledgment of the high risk, error-prone nature of an organization's activities.

Creation of a blame-free environment where individuals are able to report errors or close calls without punishment.

Expectation of collaboration across ranks to seek solutions to vulnerabilities.

Willingness on the part of the organization to direct resources to address safety concerns. (Making Healthcare Safer, 2001)

System Goals and Strategies

- Pursue patient safety initiatives that prevent medical injury.
- Promote open communication between patients and practitioners.
- Create an injury compensation that is patient-centered and serves the common good. (JCAHO, 2005)



Joint Commission National Public Safety Goals

Goal 1. Improve the accuracy of patient identification. Recommendations:

- Use at least two patient identifiers (not patient's room number) whenever administering medications or blood products, taking blood samples or other specimens for clinical testing, or providing any other treatments or procedures.

Goal 2 Improve the effectiveness of communication among caregivers. Recommendations:

- For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result "read-back" the complete order or test result.
- Standardize a list of abbreviations, acronyms and symbols that are not to be used throughout the organization. (See table below for JCAHO "Do Not Use" List.)
- Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- Implement a standardized approach to "hand off" communications, including an opportunity to ask & respond to questions.

Goal 3. Improve the safety of using medications. Recommendations:

- Standardize and limit the number of drug concentrations available in the organization.
- Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.
- Label all meds, medication containers (syringes, medicine cups, basins), or other solutions on and off the sterile field.
- Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Goal 7. Reduce the risk of healthcare-associated infections. Recommendations:

- Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or CDC hand hygiene guidelines.
- Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a healthcare-associated infection.

Goal 8. Accurately and completely reconcile medications across the continuum of care. Recommendations :

- Implement a process for comparing the patient's current medications with those ordered for the patient while under care of the organization.
- A complete list of the patient's medications is communicated to the next provider of service when a patient is referred to or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility.

Goal 9. Reduce the risk of patient harm resulting from falls.

- Implement a fall reduction program including an evaluation of the effectiveness of the program.

Goal 10. Encourage patients' active involvement in their own care as a patient safety strategy. Recommendations:

- Define & communicate the means for patients & their families to report concerns about safety and encourage them to do so.

Goal 11 The organization identifies safety risks inherent in its patient population. Recommendations?

- Identify patients at risk for suicide. (applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals—NOT APPLICABLE TO CRITICAL ACCESS HOSPITALS)

Goal 12 Improve recognition and response to changes in a patient's condition. Recommendations:

- The organization selects a suitable method that enables healthcare staff members to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening. [Critical Access Hospital, Hospital]

Clinical Opportunities

- ▣ • Appropriate use of prophylaxis to prevent venous thromboembolism in patients at risk
- ▣ • Use of perioperative beta-blockers in appropriate patients to prevent perioperative morbidity and mortality
- ▣ • Use of maximum sterile barriers while placing central intravenous catheters to prevent infections
- ▣ • Appropriate use of antibiotic prophylaxis in surgical patients to prevent perioperative infections
- ▣ • Asking that patients recall and restate what they have been told during the informed consent process
- ▣ • Continuous aspiration of subglottic secretions (CASS) to prevent ventilator-associated pneumonia
- ▣ • Use of pressure-relieving bedding materials to prevent pressure ulcers
- ▣ • Use of real-time ultrasound guidance during central-line insertion to prevent complications
- ▣ • Patient self-management for warfarin (Coumadin) to achieve appropriate outpatient anticoagulation and prevent complications
- ▣ • Appropriate provision of nutrition, with a particular emphasis on early enteral nutrition in critically ill and surgical patients
- ▣ • Use of antibiotic-impregnated central-venous catheters to prevent catheter-related infections

High 5s Project

- ▣ • Managing concentrated injectable medicines
- ▣ • Assuring medication accuracy at transitions in care
- ▣ • Communication during patient care handovers
- ▣ • Improved hand hygiene to prevent healthcare-associated infections, and
- ▣ • Performance of correct procedure at correct body sites



Institute for Healthcare Improvement (IHI)

- Prevention of ventilator-associated pneumonia
- Prevention of central-line infections
- Prevention of surgical-site infections
- Deployment of rapid-response teams*
- Assurance of optimal care for patients with acute myocardial infarction
- Prevention of adverse drug events
- Prevention of harm* from high-alert medications starting with a focus on anticoagulants, sedatives, narcotics and insulin
- Reducing surgical complications by implementing all of the changes in care recommended by SCIP, the Surgical Care Improvement Project
- Prevent pressure ulcers by reliably using science-based guidelines for their prevention
- Reducing Methicillin-Resistant Staphylococcus aureus (MRSA) infection by reliably implementing scientifically proven infection control practices
- Delivering reliable, evidence-based care for congestive heart failure to avoid readmissions
- Get boards on board by defining and spreading the best-known leveraged processes for hospitals Boards of Directors, so they can become far more effective in accelerating organizational progress toward safe care



Public Education

- ▣ The single most important way patients can help to prevent errors is to be an active members of the healthcare team. That means taking part in every decision about their healthcare. Research shows that patients who are personally involved with their care tend to get better results. Involving family
- ▣ and care takers is also an important
- ▣ part of the safety plan.



“Your HMO sent me.
Take two of these.”

- ▣ **20 Tips to Help Prevent Medical Errors**
- ▣ **US Dept. of Health & Human Service's
Agency for Healthcare Research and Quality,
September 2011**
- ▣ **<http://www.ahrq.gov/images/ahrq-logo.png>**

□ **What You Can Do to Stay Safe**

- The best way you can help to prevent errors is to be an active member of your health care team. That means taking part in every decision about your health care. Research shows that patients who are more involved with their care tend to get better results.

□

□ **Medicines**

- **Make sure that all of your doctors know about every medicine you are taking.**

This includes prescription and over-the-counter medicines and dietary supplements, such as vitamins and herbs.

- **Bring all of your medicines and supplements to your doctor visits.**

"Brown bagging" your medicines can help you and your doctor talk about them and find out if there are any problems. It can also help your doctor keep your records up to date and help you get better quality care.

- **Make sure your doctor knows about any allergies and adverse reactions you have had to medicines.**

This can help you to avoid getting a medicine that could harm you.

- **When your doctor writes a prescription for you, make sure you can read it.**

If you cannot read your doctor's handwriting, your pharmacist might not be able to either.

- **Ask for information about your medicines in terms you can understand—both when your medicines are prescribed and when you get them:**

- What is the medicine for?
- How am I supposed to take it and for how long?
- What side effects are likely? What do I do if they occur?
- Is this medicine safe to take with other medicines or dietary supplements I am taking?
- What food, drink, or activities should I avoid while taking this medicine?

- **When you pick up your medicine from the pharmacy, ask: Is this the medicine that my doctor prescribed?**

- **If you have any questions about the directions on your medicine labels, ask.**

Medicine labels can be hard to understand. For example, ask if "four times daily" means taking a dose every 6 hours around the clock or just during regular waking hours.

- **Ask your pharmacist for the best device to measure your liquid medicine.**

For example, many people use household teaspoons, which often do not hold a true teaspoon of liquid. Special devices, like marked syringes, help people measure the right dose.

- **Ask for written information about the side effects your medicine could cause.**

If you know what might happen, you will be better prepared if it does or if something unexpected happens.

- **Hospital Stays**

- **If you are in a hospital, consider asking all health care workers who will touch you whether they have washed their hands.** Handwashing can prevent the spread of infections in hospitals.

- When you are being discharged from the hospital, ask your doctor to explain the treatment plan you will follow at home.
This includes learning about your new medicines, making sure you know when to schedule follow-up appointments, and finding out when you can get back to your regular activities.
- It is important to know whether or not you should keep taking the medicines you were taking before your hospital stay. Getting clear instructions may help prevent an unexpected return trip to the hospital.
- Surgery
- If you are having surgery, make sure that you, your doctor, and your surgeon all agree on exactly what will be done.
Having surgery at the wrong site (for example, operating on the left knee instead of the right) is rare. But even once is too often. The good news is that wrong-site surgery is 100 percent preventable. Surgeons are expected to sign their initials directly on the site to be operated on before the surgery.
- If you have a choice, choose a hospital where many patients have had the procedure or surgery you need.
Research shows that patients tend to have better results when they are treated in hospitals that have a great deal of experience with their condition.
- Other Steps
- Speak up if you have questions or concerns.
You have a right to question anyone who is involved with your care.
- Make sure that someone, such as your primary care doctor, coordinates your care.
This is especially important if you have many health problems or are in the hospital.
- Make sure that all your doctors have your important health information.
Do not assume that everyone has all the information they need.
- Ask a family member or friend to go to appointments with you.
Even if you do not need help now, you might need it later.
- Know that "more" is not always better.
It is a good idea to find out why a test or treatment is needed and how it can help you. You could be better off without it.
- If you have a test, do not assume that no news is good news.
Ask how and when you will get the results.
- Learn about your condition and treatments by asking your doctor and nurse and by using other reliable sources.
For example, treatment options based on the latest scientific evidence are available from the [Effective Health Care Web site](#). Ask your doctor if your treatment is based on the latest evidence.
-
- *The term "doctor" is used in this flier to refer to the person who helps you manage your health care.

Summary

- ▣ As Leape and Berwick (2005) wrote:
- ▣ ...the most important stakeholders who have been mobilized [to advance patient safety] are the thousands of devoted physicians, nurses, therapists and pharmacists at the ground level – in the hospitals and clinics – who have become much more alert to safety hazards. They are making myriad changes, streamlining medication processes, working together to eliminate infections and trying to improve habits of teamwork. The level of commitment of these frontline professionals is inspiring.

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For your practice, your
employees...

Your Patients and
you.....

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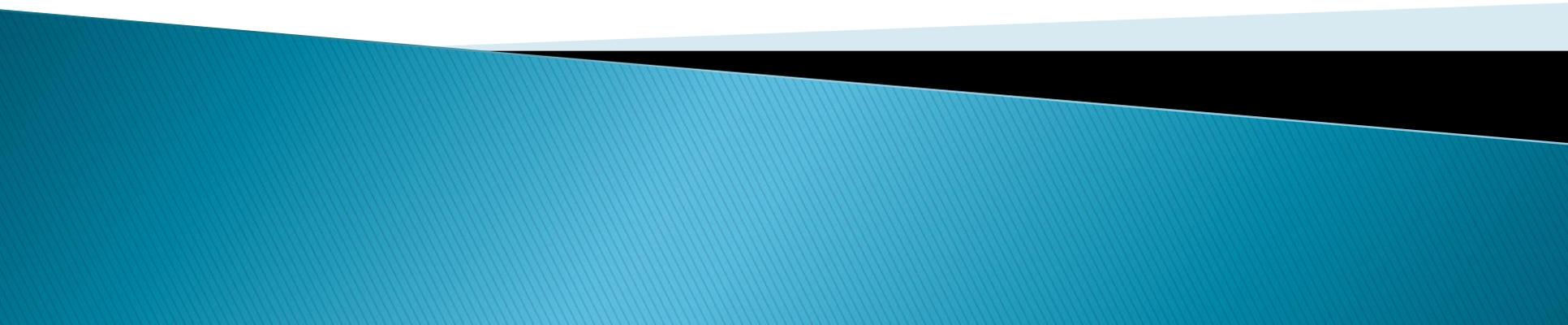


- ▣ **Cathy Robinson Pickett**
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Laws and Rules Governing Florida Nursing

Betty Barron RN MSN, MBA/HCM



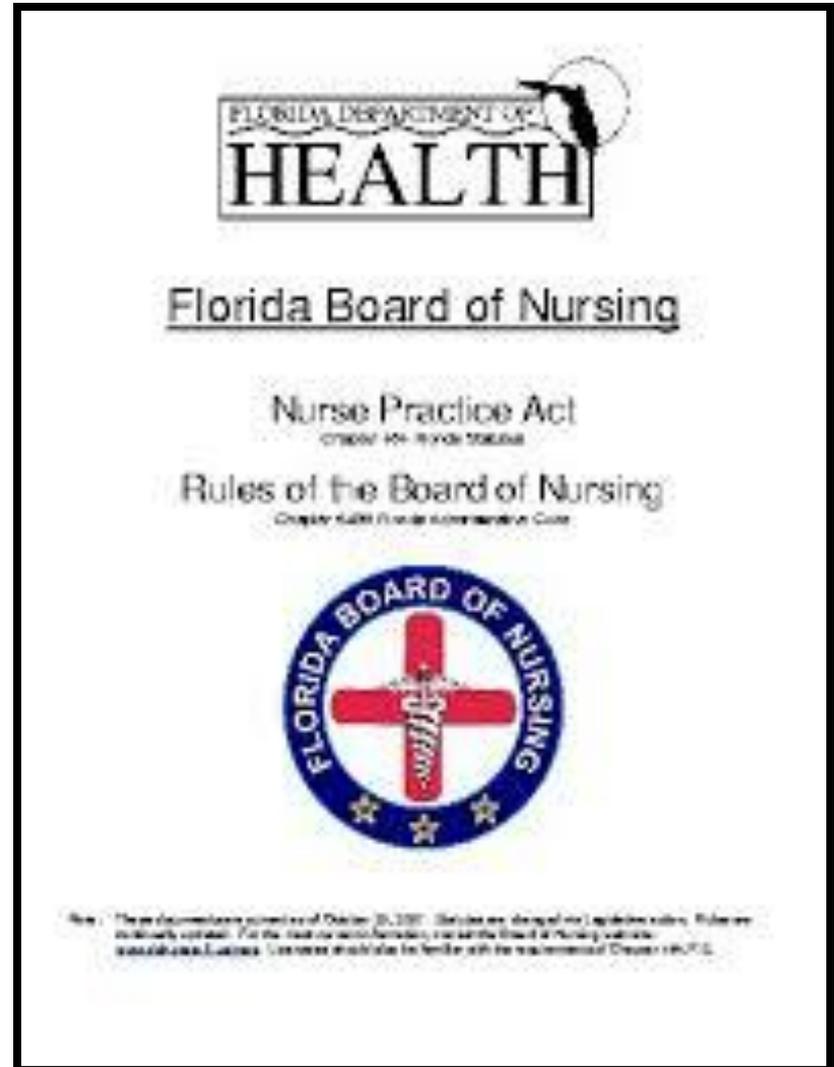


Objectives

- ▶ Describe the purpose of the Nurse Practice Act
 - ▶ Identify specific laws & rules relates to the practice of nursing
 - ▶ Describe the levels of nursing practice & general scope of each level
 - ▶ Review requirements for continuing licensure
 - ▶ Discuss discipline process as it relates to nursing
- 

Nurse Practice Act

- ▶ Legislated to safeguard the public
- ▶ Purpose:
 - Ensure minimum safety requirements met by every nurse practicing in Florida



Introduction

- ▶ Nurse Practice Act passed June 7, 1913
 - Safeguard public
 - Ensure minimum safety requirements for nurses
- ▶ Florida Statute 464
 - Regulation of professions and occupations
- ▶ Florida Statute 465
 - general provisions for all health professions
- ▶ Title 64B9
 - Statewide rules for nurses

Board of Nursing

- ▶ Every state has a nurse practice act
 - ▶ The NPA provides the guidance for the profession of nursing
 - ▶ The BON can develop administrative rules to clarify or make the law more specific
 - ▶ Under jurisdiction of the FI Dept of Health
 - ▶ Funded by licensure fees
- 

Standards of Practice

- ▶ Certified Nursing Assistant (CNA)
- ▶ Licensed Practical Nurse (LPN)
- ▶ Professional Nurse (RN)
- ▶ Clinical Nurse Specialist (CNS)
- ▶ Advanced Registered Nurse Practitioner



Certified Nursing Assistant (CNA)

- ▶ Work under supervision on RN or LPN
 - ▶ Help with ADLs

 - ▶ The duties and certifications are covered under the Nurse Practice Act
- 

Scope of Practice

- ▶ Is it within the scope of practice for a CNA in a LTC facility to assist a patient to take their medications by holding the cup of water while the patient puts one pill at a time in their mouth? (the LPN is not present)

Licensed Practical Nurse (LPN)

- ▶ Perform selected acts:
 - Treatments
 - Medication Administration
 - Health promotion/illness prevention
 - IV Therapy w/appropriate training and education
- ▶ Requirements to supervise
 - Complete 30 hour LPN supervisor course
 - No less than 6 mons of work history



Scope of Practice

- ▶ Is it within the scope of practice for an LPN with less than 6 months experience to be charge nurse on a unit of 40 patients on the 11–7 shift?

Registered Nurse (RN)

- ▶ Using specialized knowledge, judgment, skill
- ▶ Observation, assessment, nsg dx, planning, intervention, & evaluation of care
- ▶ Administer RX & treatments
- ▶ Supervise/teach other personnel



Scope of Practice

- ▶ 1. Is it within the scope of practice for a registered nurse in the state of Florida trained in ACLS to defibrillate a patient (using a defibrillator not an AED) upon recognizing ventricular fibrillation or ventricular tachycardia in an in patient or ambulatory care setting prior to ACLS code team arrival or physician verbal or written order?
- 

Clinical Nurse Specialist (CNS)

- ▶ Advanced Practice Nursing Including:
 - Assess health of individuals & families
 - Dx human responses
 - Plan health promotion; disease prevention; therapeutic intervention
 - Implement interventions based on expertise within scope
 - Coordinate/evaluate health care
- 

Advanced Registered Nurse Practitioner (ARNP)

- ▶ Certified in advanced/specialized nsg practice
- ▶ Nsg dx & treatment
- ▶ Medical dx & treatment defined by Joint Committee
- ▶ Standing Protocols
 - Under supervision of MD, DO, Dentist
- ▶ Malpractice Insurance
- ▶ Rule 64B9-4.011 submit “Dispensing Application for ARNP” to FBON

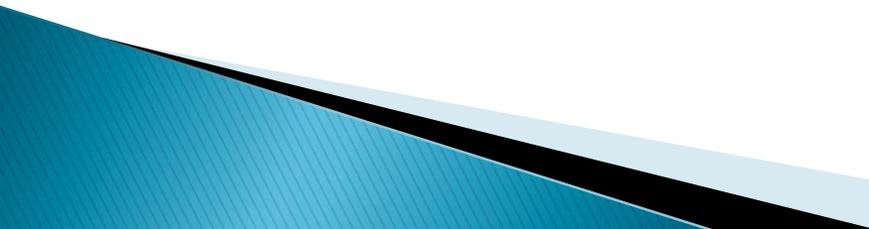


Scope of Practice

- ▶ Is an ARNP able to write orders for narcotics for patients and adjust dosages based on written protocols from attending physicians?

Continuing Licensure in Florida

▶ Biennial renewal

- 24 hrs CE
 - Approved 2 hour course on Prevention of Medical Errors
 - Two hour course on Laws and Rules
 - Every 6 years must complete 2 hour course on Domestic Violence
 - HIV/Aids completed prior to FIRST renewal
 - August 2017 – Two hour course on Recognizing Impairment in the workplace (every 4 years)
- 

Continuing Licensure in Florida

- ▶ Inactive status
 - No intent to practice
 - Renew q 2 yr
- ▶ Reactivate license
 - Apply and pay fee
 - Disclosure
 - Proof of CE for all inactive periods
- ▶ Refresher course
 - Required after 2 consecutive inactive cycles

Rule 64B9-1.013

- ▶ All licensed nurses must provide FBON:
 - Current address
 - Current place of practice
 - When moving notify within 60 days

Ethical & Legal issues

- ▶ ANA Code of Ethics for Nurses
 - Framework for ethical analysis & decision making
 - <http://nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf>
- ▶ Major Ethical Issues
 - Patient centered care
 - Advocacy
 - Delegation
 - Self care
 - Supporting colleagues and profession

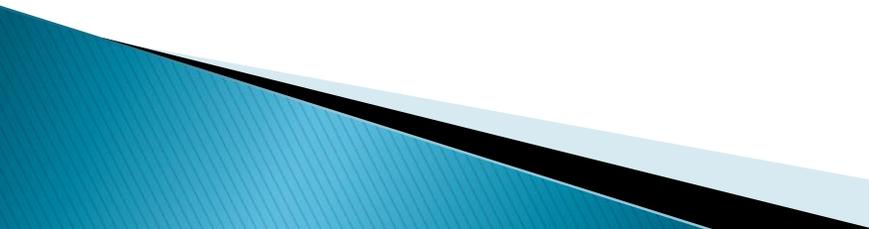
Legal Issues

- ▶ Laws governing nursing practice are different from ethical decision making framework
- ▶ Laws pertain to:
 - Documentation
 - Licensure
 - Standards of care
 - Define scope of practice
 - Accountability

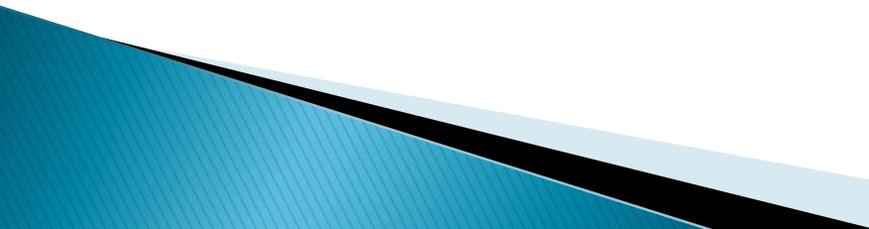
Negligence/Malpractice

- ▶ 4 Elements must be established:
 - Duty: The nurse owed a duty to meet a particular standard of care
 - Breach of Duty: Nurse failed to perform the duty owed
 - Causation: Causal connection between RN's failure & patient's injury
 - Damages: Injury occurred for which monetary compensation is adequate relief

Disciplinary Actions

- ▶ BON created to assure protection of public
 - ▶ Violations of the Board laws are punishable by disciplinary action
 - ▶ Penalties are in addition to results of legal or civil proceedings
 - ▶ Acts requiring disciplinary or legal action are outlined in sections 464.016, 464.017, and 464.018 of the Nurse Practice Act
- 

Section 464.016: Felonies

- ▶ Practicing advanced or specialized, professional, or practical nursing unless holding an active license or certificate
 - ▶ Using or attempting to use a suspended or revoked license
 - ▶ Knowingly employing unlicensed persons in the practice of nursing
 - ▶ Obtaining or attempting to obtain a license or certificate by misleading statements or misrepresentation
- 

1st Degree Misdemeanors

- ▶ Using title “Nurse”, “Registered Nurse”, “Licensed Practical Nurse”, “Clinical Nurse Specialist”, “Certified Registered Nurse Anesthetist”, “Certified Nurse Midwife”, “Advanced Registered Nurse Practitioner” or any other name/title that implies person is licensed or certified unless they are duly licensed or certified.
- ▶ Knowingly concealing information r/t violations of 464.016

Sexual Misconduct

- ▶ Violation of nurse/patient relationship where nurse induces or attempts to induce pt to engage in sexual activity outside the scope of the practice or scope of generally accepted examination or treatment of patient
 - ▶ Sexual misconduct is prohibited in the practice of nursing
 - ▶ Grounds for disciplinary action
- 

Disciplinary Action

- ▶ Attempting to procure/renew license by bribery, misrepresentation, error of the Board
 - ▶ Revoked, suspended, acted against license by another state, territory, or country
 - ▶ “Nolo Contendere” plea directly r/t practice of nursing
- 

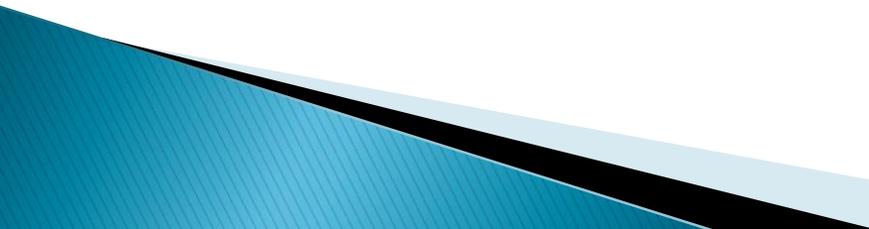
Disciplinary Action (con't)

- ▶ Guilty of:
 - Forcible felony
 - Theft, robbery, & related crimes
 - Fraudulent practices
 - Lewdness & indecent exposure
 - Assault, battery, & culpable negligence
 - Child abuse, abandonment, & neglect
 - Abuse, neglect, & exploitation

Disciplinary Action

- ▶ Making/filing false report/record, intentionally or negligently failing to file as required by state/federal law or willfully obstructing or impeding another to file
 - ▶ False, misleading, or deceptive advertising
 - ▶ Unprofessional conduct
 - ▶ Engaging or attempting to engage in possession, sale, or distribution of controlled substances for other than legitimate purpose
- 

Disciplinary Action

- ▶ Unable to practice safely due to illness, ETOH, Rx, narcotics, other chemicals
 - ▶ Failure to report above abuse
 - ▶ Knowingly violating any provision, rule, or lawful order of the Board entered in a disciplinary proceeding
 - ▶ Failure to comply with lawful subpoena
 - ▶ Failure to meet minimal stds of prevailing practice
- 

Board Recourse

- ▶ Refusal to certify or certify with restrictions
 - ▶ Suspension or permanent revocation
 - ▶ Restriction of practice or license
 - ▶ Admin fee not to exceed 10K/count or separate offense
 - ▶ Reprimand or letter of concern
 - ▶ Probation subject to Board conditions
- 

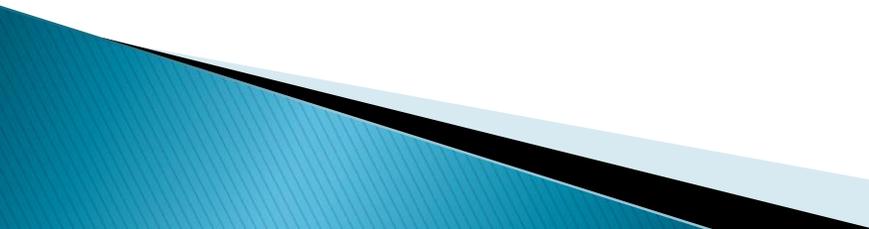
Board Recourse

- ▶ Corrective action
 - ▶ Admin fine for violations of patient rights
 - ▶ Refund of fees billed & collected from patient or 3rd party
 - ▶ Require practitioner undergo remedial education
- 

Intervention Project for Nurses (IPN)

- ▶ Established in 1983
- ▶ Does not provide treatment
 - Consolation
 - Intervention training
 - Monitoring of the nurse
- ▶ IPN is affiliate of FNA
- ▶ To make referral &/or confidential consultation: 1.800.840.2720
- ▶ Authorized by FL Statute 464/465 to assist nurses whose practice is affected.

Will participation in IPN protect my license from discipline by the FBON?

- ▶ RN reported ONLY to IPN: agrees to participate & *successfully completes IPN* = file closed & kept confidential
 - ▶ RN reported to IPN & DOES NOT agree: information forwarded to DOH
 - ▶ RN reported to IPN & DOH: disciplinary process proceeds & may result in disciplinary action
- 

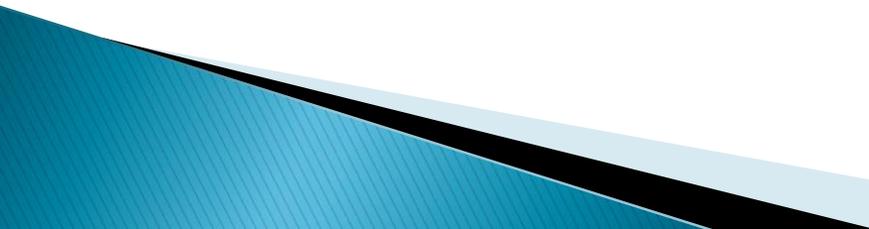
Mediation – Rule 64B9–8.012

- ▶ Mediation is acceptable resolution for 1st offense of Failure to:
 - Respond timely to CE audit
 - Issue worthless bank check for initial licensure/renewal IF licensee does not practice on delinquent license
 - ***Report address changes***
 - Pay fines & investigative costs timely
 - Timely submit proof documentation of ordered CE
 - Update practitioner profile within 15 days
 - Complete CE hours within applicable biennium

Exceptions to Nurse Practice Act

- ▶ Care by friends or family
 - ▶ Emergency
 - ▶ Students in approved school of nursing
 - ▶ GN practice
 - ▶ Nursing assistants under RN supervision
 - ▶ In accordance with practices/principles of Church of Christ Scientist
 - ▶ Working for government
- 

Exceptions con't

- ▶ Nurse licensed in another state practicing for 60 days
 - ▶ Relocating to Florida - 120 days
 - ▶ Fee for service nursing
 - ▶ Independent practice within scope
 - ▶ In home hemodialysis assistant*
 - ▶ Temporary care out of state <31 days
 - ▶ Care provided by persons enrolled in board approved remedial courses
- 

Conclusion

- ▶ FBON meetings q 2 months
- ▶ Open to public
- ▶ More info:
 - Call: 850.488.0595
 - <http://www.floridanursing.gov>
 - info@floridanursing.gov – practice issues or questions

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Boot Camp for Nurse Leaders

Leadership and Management

Betty Frandsen

MHA, NHA, RN, CDONA, FACDONA

NADONA Director of Education



NADONALTY

Learning Objectives

Differentiate between leadership and management skills

Delegate, using language designed to empower staff

Discuss time and stress management skills, and how they may improve performance

List five stages of team development, and how they affect the team's progress

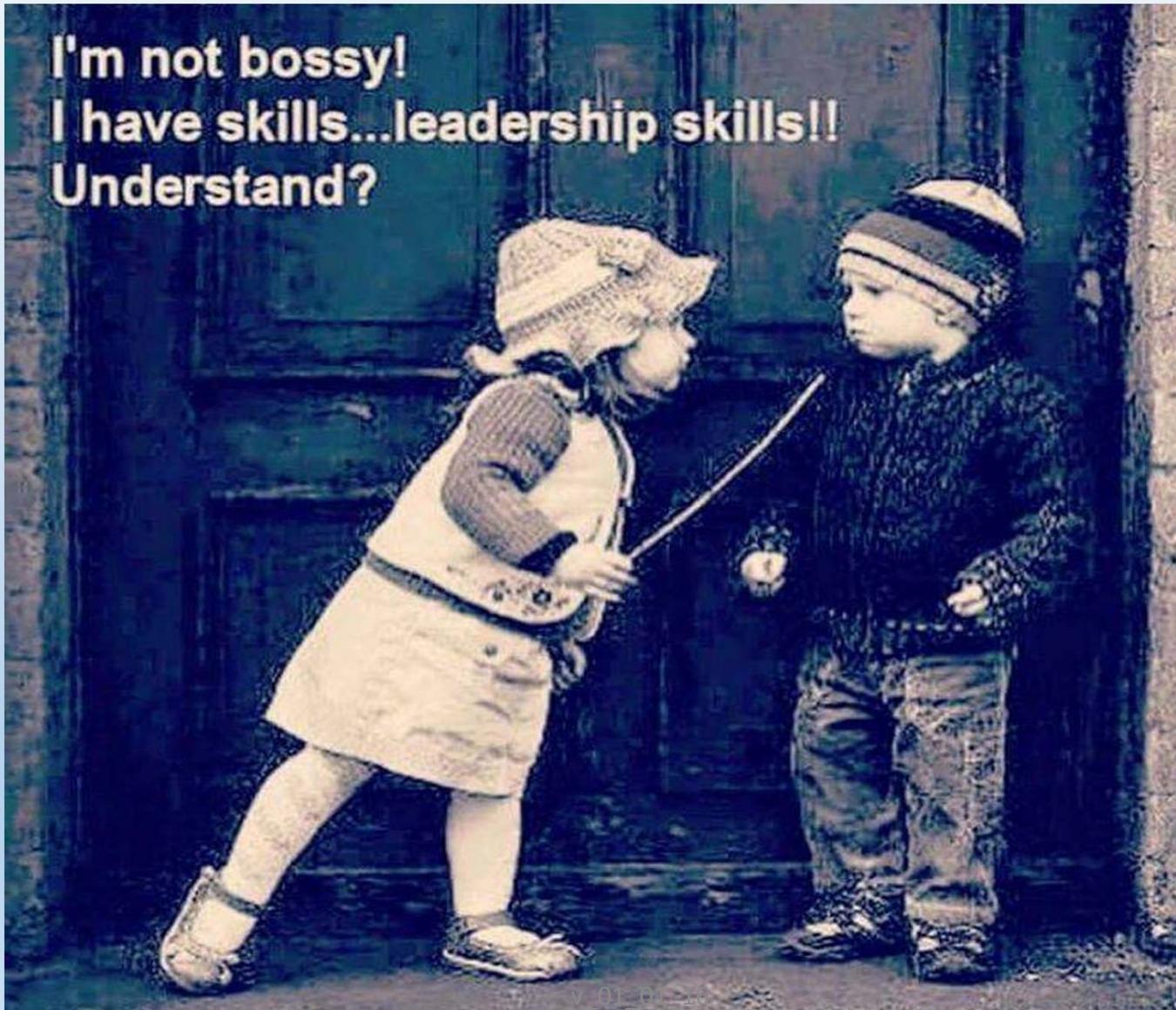
Articulate how varied personality traits impact a person's focus

What is Leadership?

Leadership is the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of the organization

A leader defines and communicates the organization's vision and goals

How are your leadership skills?



What is a leader?

Is it a person who runs things?

- No – that is a boss

Although every leader may in some sense be a boss,
certainly not every boss is a leader

Leaders...

Provide an environment of trust where individuals can learn and grow

Inspire confidence and show personal interest

Foster teamwork and a sense of community

Show kindness without being considered “easy”

Coach staff to reach their potential

Delegate properly

Make hard decisions when necessary and demonstrate confidence without being arrogant

Types of Leaders

Formal Leader

A member of an organization who has been given authority by virtue of his position to influence others to achieve organizational goals

Informal Leader

- An individual who has no formal organizational authority, but has special skills and ability that influence and lead others

Identifying Leaders

In any group setting you can identify the prominent leader easily

- Who is the person whose opinion is most valued?
- Who do others watch most when an issue is discussed?
- Who is most readily agreed with in a discussion?
- Who is the one others follow?

Is the formal or informal leader the prominent leader?

Theories of Leadership

Autocratic – tough, domineering style

Democratic – style that treats everyone equally – may be accused of being too soft and easy

Trait theory of leadership - based on the premise that leaders were successful because of their personality or personal charisma

Situational leadership - the ability to align one's style with the particular needs of the person or group one is dealing with, thus using “different strokes for different folks”

Four Basic Leadership Styles

1. Directing

- Providing specific direction and closely monitoring the accomplishment of tasks
- Communication is largely one-way: Tell staff what, when, where, how
- Directing is appropriate when:
 - A decision has to be made quickly and stakes are high
 - For inexperienced people who have the potential to learn to be self-directive
 - For someone who has skills but doesn't know the past history, established protocols, or political implications of the situation

Four Basic Leadership Styles

2. Coaching

- Brings out the best in people by helping them see their talents, abilities, and the value they add to the team
- Communication is two-way
- Works well with:
 - Staff who want to develop a particular interest or skill
 - A group that has a sense of what it wants to accomplish, but needs help learning to manage a meeting or reach consensus
 - Employees who have the basic skills but need the finer points of their new roles explained

Four Basic Leadership Styles

3. Supporting

- Leader is less directive, shares decision-making and problem-solving responsibilities, and supports others in applying their ideas
- Works best with:
 - Staff who are 2-3 years into the job and have developed ideas about how to improve the work environment
 - Experienced staff working on a short-term task force that is expected to produce results
 - New staff with demonstrated proficiency in their role, who want to implement ideas that worked in their former environment

Four Basic Leadership Styles

4. Delegating

- Leader turns over responsibility for day-to-day decision-making and problem-solving to staff
- This style offers the most latitude for authority in decisions and autonomy
- Works best for people who are self-reliant achievers, competent and committed, and do not need much direction
- The leader presents the problem and lets staff develop the solution

ineffective Leadership Styles

Micro-managing – the leader closely observes and controls the work

- Has a negative impact on morale
- Discourages staff from showing initiative

Laissez-faire

- Hands-off approach – the “sink or swim” method
- Used by inexperienced leaders who are fearful of making changes or don't know what to do, or by those at the end of their career who decide there is no point in making changes because the next person will change it again

What is Management?

Management is the act or skill of controlling and making decisions about a business, department, or other enterprise

A manager is responsible for efficiently accomplishing the goals of the organization through others

How do Managers Differ from Leaders?

Leaders have followers, and managers have subordinates

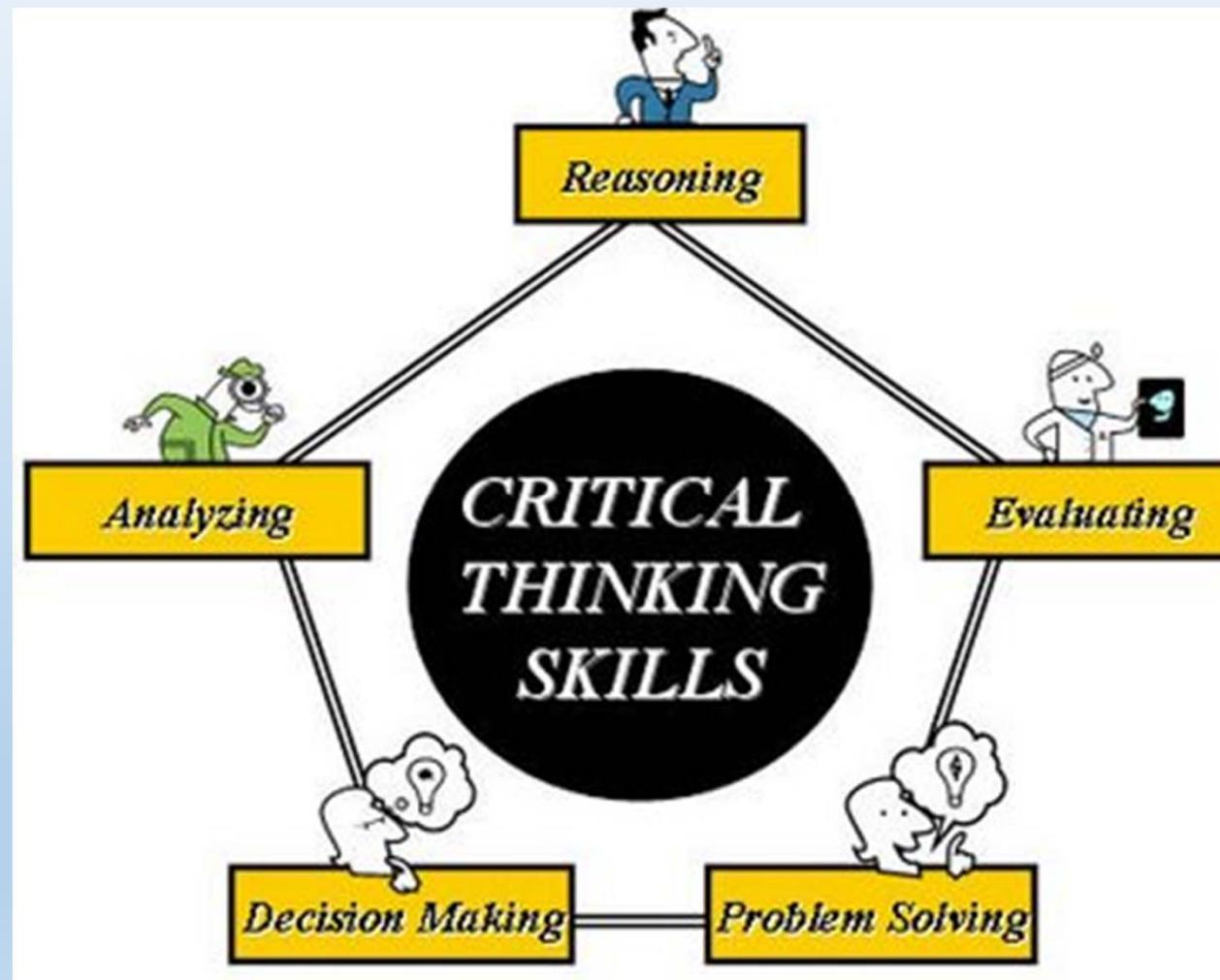
Peter Drucker identified the basic tasks of managers:

- Set objectives - decide what work needs to be done
- Organize – which activities will be performed by which staff members
- Motivate and communicate so people are prepared to get the tasks done
- Integrate persons with tasks
- Measure by setting targets and analyzing performance
- Develop people – the organization's most important asset

Critical Thinking

Disciplined thinking that is clear, rational, open-minded, and informed by evidence

Guided by professional standards and codes of ethics, not hunches or opinions



Evidence Based Practice

Applying the most current, best available research and evidence to clinical practice

Use evidence-based articles and information for policies, procedures, and nursing practice

Example: AHRQ evidence-based program, Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) has proven effectiveness of reducing patient safety issues

<http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/index.html>



Accountability and Responsibility

Accountability - the state of being accountable, liable, or answerable

Accountability means you are answerable to an authority for the activity, regardless of whether you perform it or delegate it

Responsibility - duty to satisfactorily complete a task assigned by someone that must be fulfilled and which has a consequence for failure to do so

Responsibility can be delegated, but accountability cannot

Delegation – unleashing the power of others

Delegation transfers responsibility for a procedure or task without transferring accountability

To delegate, the nurse must know the person's scope of practice, qualifications, and competence

Reasons leaders fail to delegate when they should:

- Fear the task will not be done well, or will not be done at all
- Fear of giving up control
- Time constraints for teaching the other person how to do the job
- Concerns about burdening a team member with more work

Choosing to delegate

Ask:

Is it critical that you complete the task?

Is there someone who has the expertise to complete the task?

Will the task develop another person's skills and confidence?

Can the person selected work independently?

Do you have time available to provide adequate training and to answer questions, check progress, and contribute if necessary?

Does the person have enough time to take on the work?

National Council of State Boards of Nursing: Delegation is appropriate when...



- The nurse is certain that delegating the activity is not against the law
- The person to whom the task is delegated has been taught to perform the procedure, and can demonstrate the procedure correctly if necessary
- The resident is stable and frequent, repeated assessments are not necessary
- The resident's response to the activity is reasonably predictable

Tips for Delegation Success

- Give specific details
- Be selective about what and to whom you delegate
- Delegate small tasks first
- Be a resource without taking over the project
- Give realistic timelines for completion
- Provide necessary tools and resources
- Reward and recognize success in a timely manner
- Clarify your expectations as often as needed

Benefits of Delegation

- Frees up time for you to focus on other job duties
- Builds staff self-esteem and grows new leaders
- Provides a clear message to staff that teamwork is valued
- Displays to the organization the level of trust within the department with you as the leader

Time Management



Time Management Actions

Find an organizing system that works for you. Options include:

- Spread sheet that lists tasks, goals, deadlines
- Calendar of commitments
- Day planner
- Create a system that works for you

Set priorities

Delegate responsibilities

Confront procrastination

Time Wasters

Open door policies

Failure to delegate

Too involved in personal issues

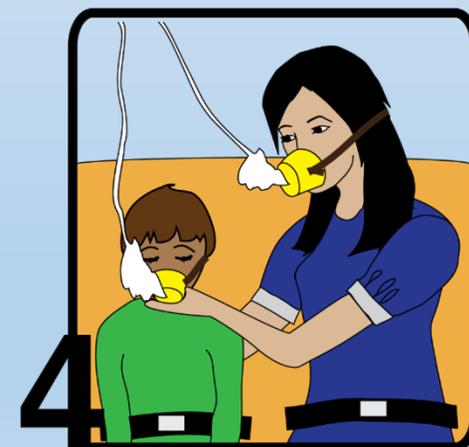
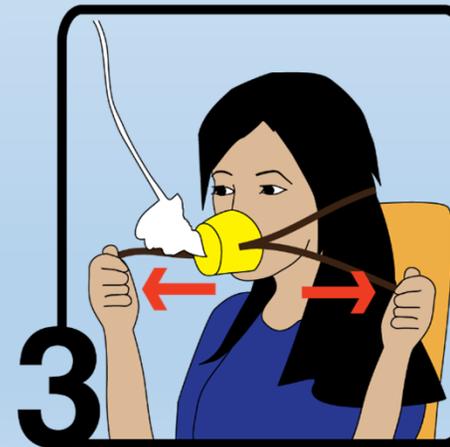
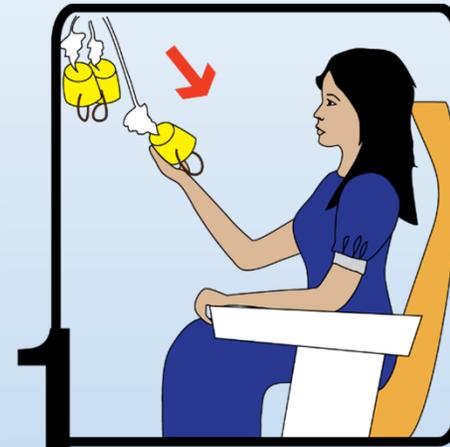
Remember....

Put your oxygen mask on first!

Take care of you!

A critical task will not get done
in your spare time

Don't be afraid to say "No"



Obstacles to Effective Time Management

Mismanagement of paper flow
and disorganization

Inability to say “No”

Interruptions

Too many things at once

Inability to delegate

Stress and fatigue

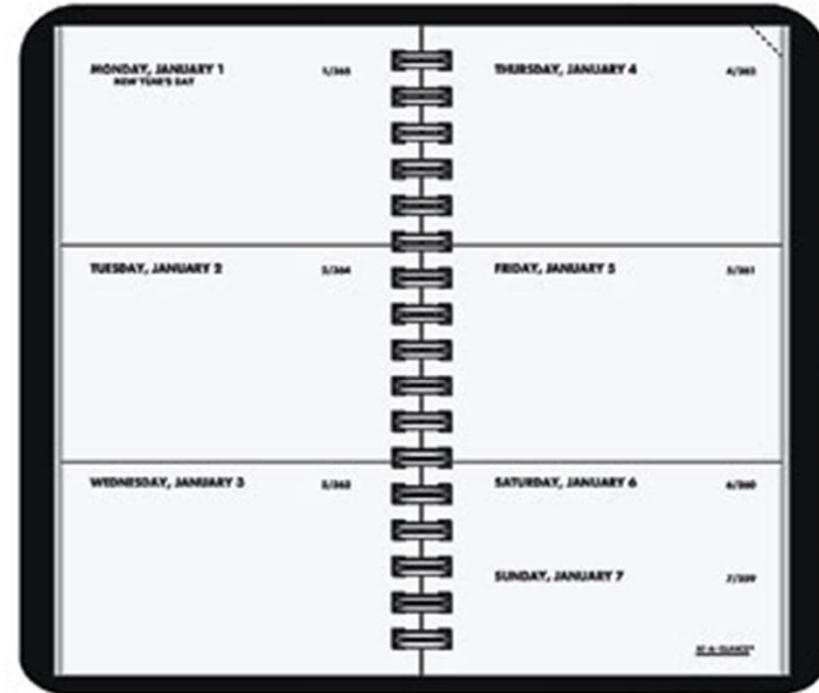
Unclear communication

- Meetings
- Procrastination and indecision
- Acting without complete information
- Dealing with employee issues
- Crisis management
- Lack of planning
- Unclear objectives and priorities

Priority Setting

Schedule your priorities,
don't prioritize your
schedule:

- Learn when and when not to reshuffle your priorities
- Consider the function or task – is it an emergency or not?
- Plan your time considering deadline dates



The Value and Challenges of Teams



- Teamwork produces results that are greater than individuals can achieve on their own
- Being a team member instills ownership in the process
- Multiple views are considered when a team is empowered to address an issue
- Common problems encountered by teams: fear of expressing one's opinion, discrediting of ideas, feuding of team members, following opinions rather than facts

Stages of Team Development

1. Forming – most team members are positive and polite. They are learning about the assignment and getting to know each other.
2. Storming - conflict can occur between team members' natural working styles and differing opinions, and as they resist boundaries established by the leader.
3. Norming - people start to resolve their differences, appreciate colleagues' strengths, and respect the authority of the leader.
4. Performing - hard work leads, without friction, to the achievement of the team's goal. The structures and processes the leader set up support this.
5. Adjourning or Mourning – as assignments end, team members who have developed close working relationships may find the end of the assignment difficult.

Leading a Team

Explain "forming, storming, norming, and performing," so team members understand why problems occur.

Identify the stage of team development that your team is in.

Be positive and firm when your leadership is challenged.

Respond quickly to difficulties. Change your approach at each stage so the team grows in performance.

Consider what you need to do to move them towards the performing stage.

Schedule regular reviews of the team's progress.

Communication

Communication is an essential skill for nurse leaders

Problems occur when:

- We only hear what we expect to hear
- We have preconceived ideas of what people mean
- Perceptions of the source and the recipient are different
- We evaluate the messenger rather than the message
- Our emotional state affects what we hear

Communication

Methods

- Verbal
- Written
- Body language
- Gestures

Tips

- Gather your thoughts first
- Choose your words – simple, not offensive
- Manage your tone
- Use eye contact
- Pay attention to body language
- Concentrate / focus
- Listen two-way

The Art of Active Listening

Take time to probe and listen – Ask “What makes that so important to you.” “Tell me more.” “What else do I need to know?”

Non-verbally communicate that you are listening – maintain eye contact, nod your head

Listen to understand – try to first understand what staff are telling you before making sure you are understood

Paraphrase or restate what you hear – Say “If I heard you correctly, then.....” “I hear you saying that....” “The situation then, is....”

Act on staff requests – they only know they were heard if you take action on what they said

Test your ability to benefit from listening...

- What did I learn from the other person?
- What did I learn about the other person?
- Who did more talking? More listening?
- Did anyone interrupt?
- What questions should I have asked or answered more thoroughly?
- Did I ask for clarification?
- Did I practice acknowledgement?
- Was everyone paying attention?
- What will I do differently in my next conversation?

Myers Briggs Personality Traits

Carl Jung developed a theory about human personality traits he called 'psychological type.'

Katherine Cook Briggs and Isabel Briggs Myers expanded his work by developing the Myers-Briggs Type Indicator (MBTI) instrument that is used widely to give insight into personality traits

There are 16 variations of MBTI traits that are based on responses to the instrument. Each individual has a distinct combination of the following traits:

- Extraversion or Introversion
- Sensing or Intuition
- Thinking or Feeling
- Judging or Perceiving

Q vs EQ

IQ – intelligence quotient:

- a measure of a person's intelligence as indicated by an intelligence test
- the ratio of a person's mental age to their chronological age (multiplied by 100)

EQ (or EI) - emotional (intelligence) quotient:

- a measure of a person's adequacy in areas such as self-awareness, empathy, and dealing sensitively with others

Components of EQ

Four main constructs of Daniel Goleman's EQ (EI) model:

- Self-awareness – ability to read one's emotions and recognize their impact
- Self-management – controlling of one's emotions and impulses and adapting to changing circumstances
- Social awareness – ability to sense, understand, and react to other's emotions
- Relationship management – ability to inspire, influence, and develop others while managing conflict

Stress Management

Psychologist Richard Lazarus says stress is a feeling experienced when a person perceives that demands exceed the personal and social resources he or she can mobilize.

We experience stress when we feel out of control

Individuals with varied personality types experience stress differently

Consequences of stress include negative physical and psychological impact, poor health, and burnout syndrome

Nurses are prone to compassion fatigue from caring for others without refreshing self

Is it Burnout or Compassion Fatigue?

Burnout

Cumulative process marked by emotional exhaustion and withdrawal associated with increased workload and institutional stress that is NOT trauma-related.

Stages of Burnout: enthusiasm, stagnation, frustration, apathy

Compassion Fatigue

- Emotional strain of working with those suffering the consequences of traumatic events
- Can occur due to exposure to one case or from a “cumulative” level of trauma
- Faster onset and more rapid recovery than burnout

Stress Relief Tips

Better manage your time. Identify the things that are most important and do them first.

Take care of yourself. Eat well. Don't smoke. Limit alcohol use. Seek counseling to gain perspective.

Acknowledge things you can't control.

Learn to say "No."

Speak up tactfully. Not talking about your needs and concerns creates stress and makes negative feelings worse.

Ask for help at work and at home. Delegate.

Stress Relievers...

- Name 3 things you feel grateful for today
- Think of something that has brought you a sense of joy
- Who do you love that you can reach out to today? (Call them!)
- What made you laugh today? (Share it!)
- Find your passion - balancing life involves putting the things that we value and have passion for in our schedule.
- Have quiet alone time in a calm place where you feel renewed
- Find ways to acknowledge loss and grief
- Stay clear with commitment to career goals or your personal mission
- Focus on what you can control
- Look at situations as challenges and opportunities, not problems or stresses

Questions



Boot Camp for Nurse Leaders

Human Resources

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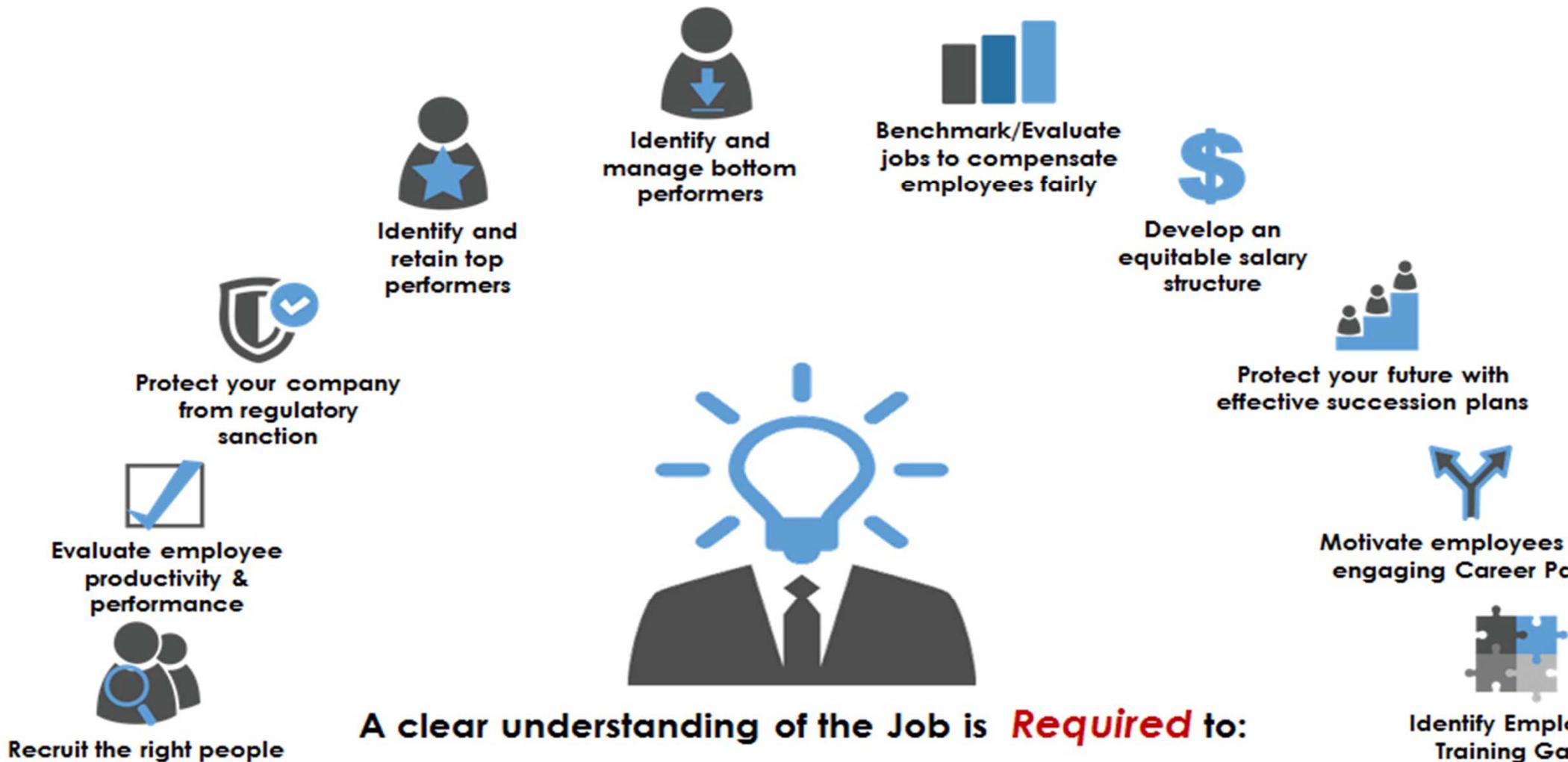


NADONALTY

Learning Objectives

- Discuss how job descriptions and performance appraisals are meaningful tools in the effort to improve resident outcomes
- List 3 questions that should not be asked during an employment interview
- Explain the difference between staffing by hours-per-patient-day and acuity-based staffing
- Identify 3 employment laws that are important in the nursing home setting

HR Tasks for the Nurse Leader



*From <http://www.hrtms.com/job-description-management.html>

Recruiting The Right People

Have a clear picture in mind of target requirements for the position to be filled

- Specialty unit – medically complex, sub-acute rehab, hospice, dementia care, wound care
- Resident acuity needs – IV therapy, tube feedings, trach care/suctioning, dementia or behavioral care, bariatrics, wounds
- Resident preferences – male or female caregiver



Back Ground Checks and References

Inform the applicant that criminal background checks are required

- Check your state and any previous states in which the applicant worked or lived
- The facility must not employ individuals found guilty of abusing, neglecting, or mistreating residents by a court of law; or have a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property (F225)

Check professional references before making an employment offer

- References should not be from friends or co-workers only
- Attempt to obtain 2 professional references

Verify licensure/nurse aide registry

Interviewing

Closed questions – require a yes/no response

- “Now that you have reviewed the job description, do you think you are qualified for this job?”

Open-ended questions – require the applicant to explain:

- “Now that you have reviewed the job description, please explain why you are qualified for this job.”
- “Why is it important to...?”
- “How would you ...?”

Behavior-based questions – ask the applicant to explain his/her actions in detail:

- “Give me an example of a time when you had to ...”
- “What would you do if you witnessed ...?”

Questions Not to Ask

- What is your religious affiliation?
- Are you pregnant?
- What is your political affiliation?
- What is your race or ethnicity?
- How old are you?
- Are you disabled?
- Are you married?
- Do you have children or plan to?
- Is your spouse employed?
- Are you in debt?
- Do you drink or smoke?



The Successful Interview

Let the applicant know you will be taking notes

Manage the interview – use the allotted time efficiently – don't let a talkative applicant take over

Allow silence – give the applicant time to think

Awkward response – follow with a neutral comment, proceed to next question

Explain job in detail

Background checks will be conducted

- Do not ask about disability – ask questions that focus on job requirements – Are you able to lift 50 pounds? Can you transfer a resident from a lying position to a wheelchair?
- Avoid making hasty judgements either way
- End interview early if problems are uncovered or application contains false information
- Allow time for questions
- Have a peer conduct tour

The Importance of Job Descriptions

Scope of responsibility is a main focus of a job description

Provides the foundation for an employee's performance

Must include:

- Job title
- Clear job requirements
- Essential duties
- Required skills and knowledge/licensure/educational requirement
- Physical requirements
- Expected abilities
- Who the employee will report to

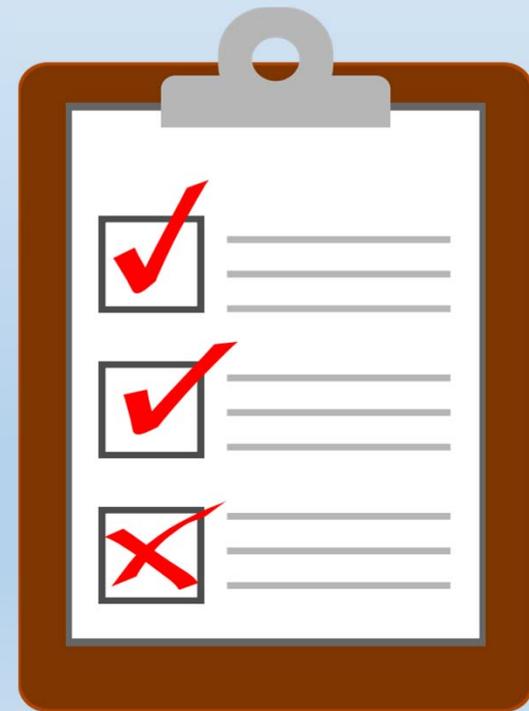
Performance Appraisals

Evaluate all employees in comparable positions consistently using the same standards

Measure performance against

- Job description elements
- Policies and procedures
- Standards of practice
- Mission and vision statements
- Goal achievement
- QAPI involvement
- Corporate compliance expectations

- Identify and retain good performers
- Identify and manage poor performers



Staff Development Needs

Compare each employee's performance against his or her job description categories

- Complete a performance review of every nurse aide at least every 12 months (F497)
- Ensure services meet professional standards of quality (F281)
- Identify areas of weakness as determined by performance reviews and develop training programs that address educational needs

Through QAA/QAPI efforts identify areas of performance where staff need additional education to improve outcomes

Orientation Process

Organization

Organizational structure
Tour
Location of cafeteria, time clock, restrooms
Vision/Mission
History/Background
Policies that affect all
Working conditions, privileges, duties
Employee Handbook
Rules, regulations, benefits
Disaster plan/safety training

Department

- Departmental standards
- Meet fellow employees
- Where and to whom to report
- Exact hours of work and break
- Rules and regulations
- Nursing standards – P&Ps
- Dress code – uniform purchase
- Security devices, alarms
- Common items staff need to access

Preceptor Program

Preceptor is primary staff member who assists new hire through orientation process

Good match = peer-to-peer relationship

Helps new staff perform and gain skill

Explains P&Ps

Assists new hire in learning residents' background, wants, and needs

Facilitates fitting in with others

Follows up to assure comfort level and good fit



Disciplinary Process

Use progressive discipline when appropriate

- Be consistent
- Discipline in private
- Always have a respectful manner

Remember – the intent of a disciplinary process is performance improvement

- Focus on the behavior as the problem, not the person
- Explain the standard and why the behavior did not meet it
- Ask the employee to set goals for improvement
- Follow-up

Document all interactions with the employee

Benchmarking Through Salary Surveys

Conduct a wage and salary survey to learn if your facility is competitive with other nursing homes and businesses in the area

Two types of salary surveys

- General salary survey – collect wage and salary information about organizations that pay a similar wage - fast food restaurants, stores, etc.
- Focused salary survey – collect wage and salary information about organizations competing to hire the same people - other nursing homes, home health, hospitals, etc.

Employee Compensation

Exempt employees

- Salaried position - not based on hours worked
- Typically management and professional positions
- Exempt from certain wage and hour laws (e.g., overtime)

Non-exempt employees

- Paid a per-hour rate
- Must be paid time and a half for hours over 40 per week, 80 per 2 weeks
- Typically receive differential for 2nd and 3rd shift work

Withholding of federal and state tax and FICA (social security)

Employee Personnel File

Personnel File

Application and resume
Reference checks
Signed job description
Receipt/Review of Handbook
Orientation and training records
I-9 & W-4
Performance records
Emergency contact information
Payroll information

Medical File

- Pre-employment history and physical
- TB testing dates, results and chest x-ray if required
- Hepatitis B vaccination records
- Influenza immunization records
- Other confidential health information

Staffing vs. Scheduling

Staffing – identifying the quality and quantity of RNs, LPNs, and CNAs that are needed to meet the needs of the residents and perform the required tasks

Scheduling – assigning available staffing resources per shift and unit

- 8-40 pattern – 5 eight hour days per week
- 8-32 pattern – 4 eight-hour days per week
- 7-70 pattern – 7 ten-hour days per two-weeks
- 12 hour shifts – 3 days per week, often for 40 hours pay
- Baylor Plan – twelve hour shifts weekends only
- 16 hour shifts – weekend option
- Self-scheduling – staff work together to plan and control their own schedule based on established guidelines

Staffing – How much is enough?

Factors that influence staffing needs:

- Resident census and level of acuity
- Specialty units
- Layout of the unit and facility
- Medication system
- Availability of support services
- Characteristics of staff
- Absenteeism and turnover rates
- Scheduling constraints

Position Control

Define optimum staffing standards for each unit

Define minimum staffing needed for each unit to meet resident needs

- Consider skill mix of staff and acuity of residents
- Helps justify overtime
- Provides the basis for mandating if allowed in your state

Position Control – develop a master list of all nursing personnel and their respective FT/PT equivalent

- Prevents over hiring
- Displays open positions
- Helps maintain the staffing budget

Compare actual to budgeted FTEs and address variances

Staffing Calculations

Hours Per Patient Day (HPPD) – the amount of direct care time provided to a resident in a 24 hour period

CMS expected numbers are available in the Five Star Quality Rating System Technical User's Guide and are adjusted based on reported RUGs groups in each facility

Example

Census at midnight = 100 residents

Total RN, LPN, CNA hours worked in 24 hours = 370

370 hours divided by 100 residents = 3.70 HPPD for all nursing staff

This falls within the average national staffing for a 3-Star Staffing rating (3.661 – 4.172)

Staffing Calculations (cont'd)

Acuity Based Staffing – conduct a time study of how long it takes RNs, LPNs, CNAs to care for each RUG group in your facility by shift, multiply by number of residents in each RUG category, divide by 8 hours to see how many RNs, LPNs, CNAs are needed per shift based on acuity levels; **OR**

Look at Five Star Expected and Adjusted Staff Time Values for your specific facility by visiting <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs.html>

Staffing the Shifts

Productive Hours – actual hours worked (not budgeted or scheduled)

- Excludes vacation, sick time, orientation, educational leave, holidays, or committee time

Traditional Staffing Allocation for a 24-Hour Period

- 50% of employees on day shift
- 33% of employees on evening shift
- 17% of employees on night shift

Adjust staffing allocation per shift based on individualized resident needs

Calculating Turnover Rates

Divide the number of employees who were terminated or who resigned by the number of employees X 100% = turnover rate

Example

There are 110 full time equivalent (FTE) employees in the nursing department. During the month, 12 separated from employment. Using the formula above:

$$12 \text{ divided by } 110 = .109 \times 100\% = 10.9\%$$

The turnover rate was 10.9% for the month

Key Employment Laws

Americans with Disabilities Act (ADA) – prohibits discrimination against qualified individuals with disabilities in employment practices such as job application procedures, hiring, firing, advancement, compensation, training, working conditions, and privileges/employment. Requires reasonable accommodations

- Disability = a physical or mental impairment that substantially limits one or more major life activities
- <http://www.dol.gov/dol/topic/disability/ada.htm>

Civil Rights Act – prohibits discrimination because of race, color, religion, sexual orientation, national origin, or marital status

- Established Equal Employment Opportunity Commission (EEOC)
- <http://www.eeoc.gov/laws/statutes/titlevii.cfm>
- <http://www.eeoc.gov/laws/types/age.cfm> - prohibits discrimination based on age 40 and over

Key Employment Laws (cont'd)

Consolidated Omnibus Reconciliation Act (COBRA) – gives workers who lose health benefits the right to choose to continue group health benefits for a limited time

- <http://www.dol.gov/dol/topic/health-plans/cobra.htm>

Health Insurance Portability and Accountability Act (HIPAA) – protects coverage under group health plans that limit exclusions for preexisting conditions; prohibits discrimination against employees/dependents based on health status; allows opportunity to enroll in a new plan in certain circumstances

- <http://www.hhs.gov/ocr/privacy>

Key Employment Laws (cont'd)

Fair Labor Standards Act (FLSA) – requires employers to pay employees not otherwise exempt at least federal minimum wage and overtime pay 1½ times the regular rate. Restricts hours children under age 16 can work; limits hours children under 16 can work in agricultural operations during school months; prohibits working in jobs deemed too dangerous until age 18

- <https://www.dol.gov/whd/regs/statutes/FairLaborStandAct.pdf>

Family and Medical Leave Act (FMLA) – provides eligible employees up to 12 weeks of unpaid, job-protected leave per year with group health benefits maintained during leave; those caring for a covered service member are entitled to 26 work weeks in a 12-month period

- <http://www.dol.gov/dol/topic/benefits-leave/fmla.htm>

Key Employment Laws (cont'd)

Occupational Safety and Health Administration Act (OSHA) – workplace safety standards and whistleblower protection from retaliation for reporting unsafe acts, injuries, or other protected activities

- www.osha.gov
- <http://www.whistleblowers.gov>

Unemployment Compensation – unemployment insurance based on dual federal and state statutes provides employees who lost their job through no fault of their own with monetary payments for a given period of time or until they find a new job

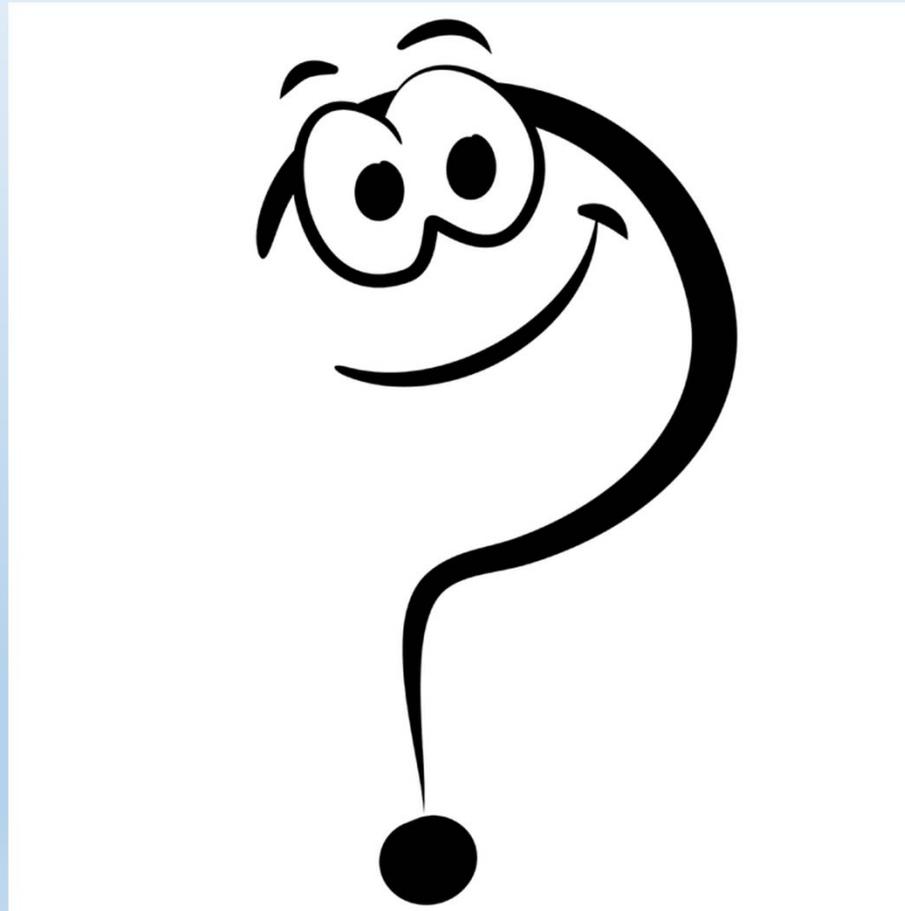
- <http://www.dol.gov/dol/topic/unemployment-insurance>

Additional Resources

State Operations Manual Appendix PP

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_tcf.pdf

Questions



Boot Camp for Nurse Leaders

QAA and QAPI

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NADONALT

Learning Objectives

Examine the enhancements to QAA regulations as published in the CMS July 16, 2015, Proposed Rule

Discuss the CMS expectations for QAPI as published in the July 16, 2015, Proposed Rule

Explain how to use the Fishbone Cause and Effect Diagram and the Five Whys Tool

Describe the PDSA Cycle and key information for each component

What is QAPI?

Quality Assurance (QA) and Performance Improvement (PI) is the merger of two complimentary approaches to quality management

QA is

- a process of assuring that care reaches an acceptable level
- a retroactive, retrospective effort to examine why a certain quality standard was not met

PI is a proactive, continuous study of processes with the intent of preventing or decreasing the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems

(CMS QAPI News Brief)

§483.75 QAPI

) Quality Assurance and Performance Improvement (QAPI)

Each facility ... must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of outcomes of care and quality of life. The facility must:

- Maintain documentation and demonstrate evidence of its ongoing QAPI program
- Present its QAPI plan to the State Agency Surveyor at the first annual recertification survey after the effective date of the regulation, at each annual survey, and upon request
- Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements upon request

Five Elements of QAPI

1. Design and Scope
2. Governance and Leadership
3. Feedback, Data Systems, and Monitoring
4. Performance Improvement Projects (PIPs)
5. Systematic Analysis and Systemic Action



Program Design and Scope (Element 1)



The QAPI program must be ongoing, comprehensive, and address the full range of care and services provided by the facility. It must:

- 1) Address all systems of care and management practices;
- 2) Include clinical care, quality of life, and resident choice;
- 3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and operation predictive of desired outcomes for residents.
- 4) Reflect the complexities, unique care, and services that the facility provides

Governance and Leadership (Element 2)



The governing body/executive leadership are responsible and accountable for ensuring that:

An ongoing QAPI program is:

- defined, implemented, and maintained and addresses identified priorities
- sustained during transitions in leadership and staffing
- adequately resourced, including staff time, equipment, and technical training; and identifies and prioritizes problems and opportunities based on performance indicator data, and resident and staff reflect organizational processes, functions, and services provided to residents

Corrective actions address gaps in systems, and effectiveness is evaluated

Clear expectations are set for safety, quality, rights, choice, and respect

Program Feedback, Data Systems and Monitoring Element 3)



Establish and implement written policies & procedures for:

adverse event monitoring

systems to obtain and use feedback and input from direct care workers, other staff, residents, and resident representatives, and how the information will be used to identify high risk, high volume, or problem-prone issues

systems to identify, collect, and use data from all departments and how the information will be used to develop and monitor performance indicators

Program Feedback, Data Systems and Monitoring Element 3) (cont'd)



Establish and implement written policies & procedures for development, monitoring, and evaluation of performance indicators, including the methodology and frequency

adverse event monitoring, including methods by which staff will systematically identify, report, track, investigate, analyze, and use data and information relating to adverse events

how staff will use the data to develop activities to prevent adverse events

Program Activities (PIPs) (Element 4)



Set priorities for performance improvement activities (projects) that:

- focus on high-risk, high-volume, or problem prone areas
- consider incidence, prevalence, and severity of the problems
- affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care
- track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility

Program Activities (PIPs) (Element 4) (cont'd)



Set priorities for performance improvement activities that:

Conduct distinct performance improvement projects (PIPs), with the number and frequency reflective of the scope and complexity of the facility's services and available resources

Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis

Program Systematic Analysis and Systemic Action (Element 5)



The facility must:

Take performance improvement actions, implement the actions, measure success, and track performance to ensure improvements are realized and sustained

Develop and implement policies addressing how to use a systematic approach to determine underlying causes of problems impacting larger systems

Develop corrective actions to effect change at the systems level and to prevent quality of care, quality of life, or safety problems

Monitor the effectiveness of performance improvement activities to ensure that improvements are sustained

Quality Assessment and Assurance (QAA)



- 1) According to the July 16, 2015 Proposed Rule, a facility must maintain a quality assessment and assurance committee consisting of
- (i) The director of nursing services;
 - (ii) The medical director or his/her designee;
 - (iii) At least 3 other members of the facility's staff, at least one of who must be the administrator, owner, a board member, or other individual in a leadership role; and
 - (iv) The infection control and prevention officer.

QAA (cont'd)

) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI Program....The committee must:

-) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which QAA activities, including performance improvement projects (PIPs) required under the QAPI program are necessary; and
-) Develop and implement appropriate plans of action to correct identified quality deficiencies; and
- i) Regularly review and analyze data resulting from drug regimen reviews, and act on available data to make improvements.

QAA (cont'd)

h) Disclosure of information

- 1) A State or the Secretary may not require disclosure of records of the committee except when disclosure is related to the compliance of the committee with requirements of this section.
- 2) Demonstration of compliance ... may require State or Federal survey access to:
 - i. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events;
 - ii. Documentation demonstrating development, implementation, and evaluation of corrective actions or performance improvement activities, and ...

QAA (cont'd)



- (iii) Other documentation considered necessary by a State or Federal surveyor in assessing compliance.
- i) Sanctions – good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions

2 Action Steps to QAPI



Step 1: Leadership Responsibility and Accountability

Develop a steering committee and provide resources

Establish a climate of open communication and respect

Recognize how the internal culture will promote performance improvement

Step 2: Develop a Deliberate Approach to Teamwork

Assess the effectiveness of teamwork in your facility

Discuss how PIP teams will address QAPI goals, and include direct care staff, residents, and families

Enhance communication structures

12 Action Steps to QAPI (cont'd)



Step 3: Take your QAPI “Pulse” with a Self-Assessment

Complete the CMS Self-Assessment Tool with input from the right people
Record the answers for future comparison

Step 4: Identify your organization’s Guiding Principles

Develop a purpose statement –that describes how QAPI supports your overall vision and mission

Establish guiding principles that describe the beliefs and philosophy of your facility pertaining to QAPI

Define the QAPI scope in your organization – list the types of care and services provided by all departments

Assemble the purpose statement, guiding principles, mission and vision statements – these become the preamble to your written QAPI Plan

12 Action Steps to QAPI (cont'd)



Step 5: Develop Your QAPI Plan

Give the *Guide for Developing a QAPI Plan* (from QAPI at a Glance) to team members and have them write the plan

Review the plan and set a date to finalize it

Step 6: Conduct a QAPI Awareness Campaign

Inform everyone about QAPI and your written QAPI Plan

Provide training and education on QAPI to all

Develop a communication strategy for engaging all caregivers, residents, and families

L2 Action Steps to QAPI (cont'd)

Step 7: Develop a Strategy for Collecting & Using Data

Decide what data you will monitor routinely

Set performance targets and identify benchmarks

Decide who will collect the data, who will review it, frequency of collection, and reporting methods

Step 8: Identify Your Gaps and Opportunities

Look for gaps in care systems and opportunities for improvement

Include residents and caregivers in discussions

Identify what is being done well

Prioritize improvement activities

12 Action Steps to QAPI (cont'd)

Step 9: Prioritize Opportunities & Charter PIPs

- Identify which problems will be selected for a PIP focus
- Charter PIP teams, select leaders, and define the PIP mission
- Develop a timeline, estimated budget, use Goal Setting Worksheet

Step 10: Plan, Conduct and Document PIPs

- Give the PIP team information they need
- Set a timeline
- Select or create measurement tools
- Prepare and present results
- Use a problem solving tool such as PDSA to develop action plan
- Report results to overseeing committee

L2 Action Steps to QAPI (cont'd)



Step 11: Get to the “Root” of the Problem

Use a methodical approach to identify root causes, such as the PDSA Cycle

Step 12: Take Systemic Action

Implement actions designed to improve performance or reduce the chance of recurrence

Target root causes with strong interventions

Pilot test large-scale changes before launching facility-wide

Writing the QAPI Plan

Use the *CMS Guide to Developing a QAPI Plan* to guide your efforts

Obtain the guide:

<https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/qapiplan.pdf>



PDSA Model for Improvement

Train staff in how to use the Plan-Do-Study-Act model

Make observations of the system targeted for improvement

- Examples: staff performance, processes or service delivery, documentation, staffing, organizational culture, etc.

The PIP team using the PDSA model should ask:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

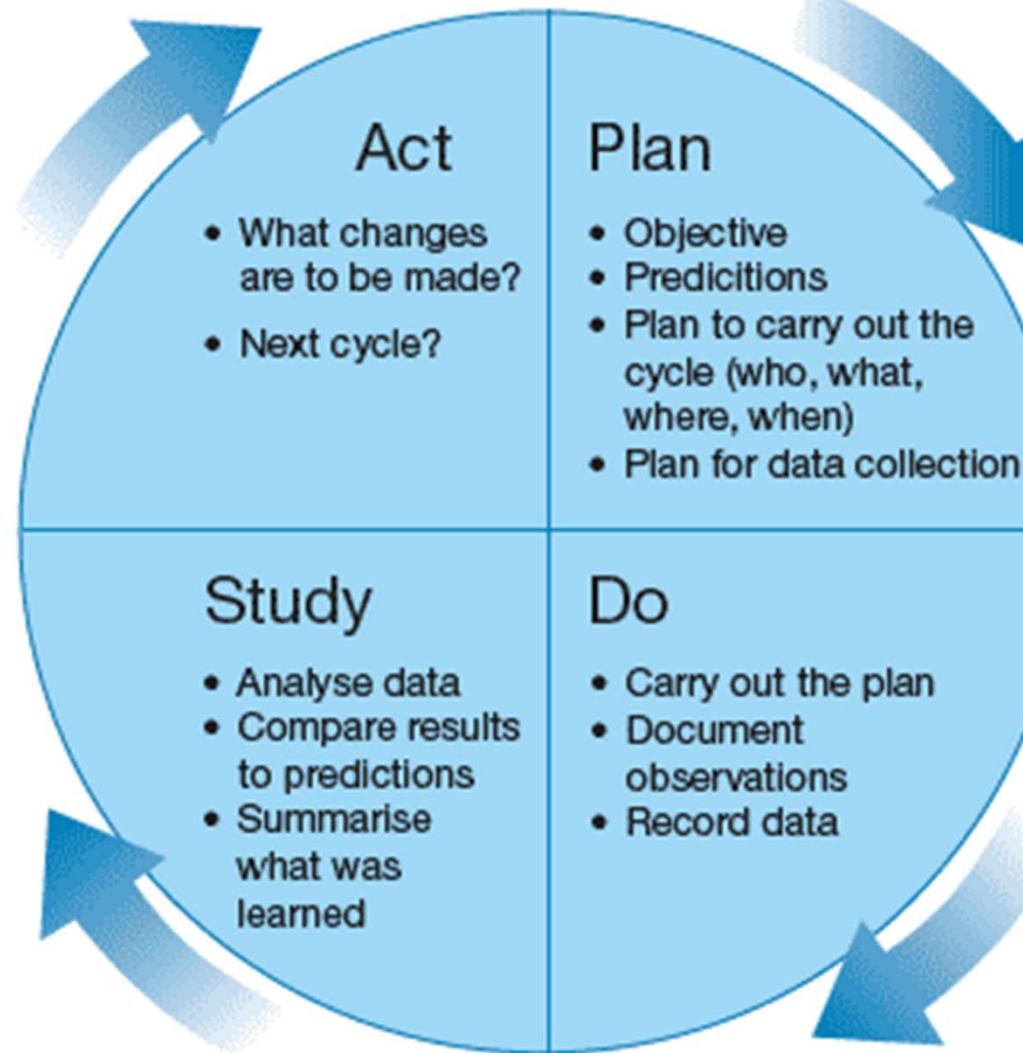
DSA Cycle

Plan to improve performance – what areas are not strong and what can you do about it?

Do carry out your plan – document what you see when the plan is carried out

Study the results – step back and look at the big picture. Has there been improvement?

Act on the basis of your findings. Continue with the change, make further changes, or stop?



Root Cause Analysis (RCA)

A systematic process for identifying contributing casual factors that underlie variations in performance

Discover the underlying cause so effective interventions can be implemented

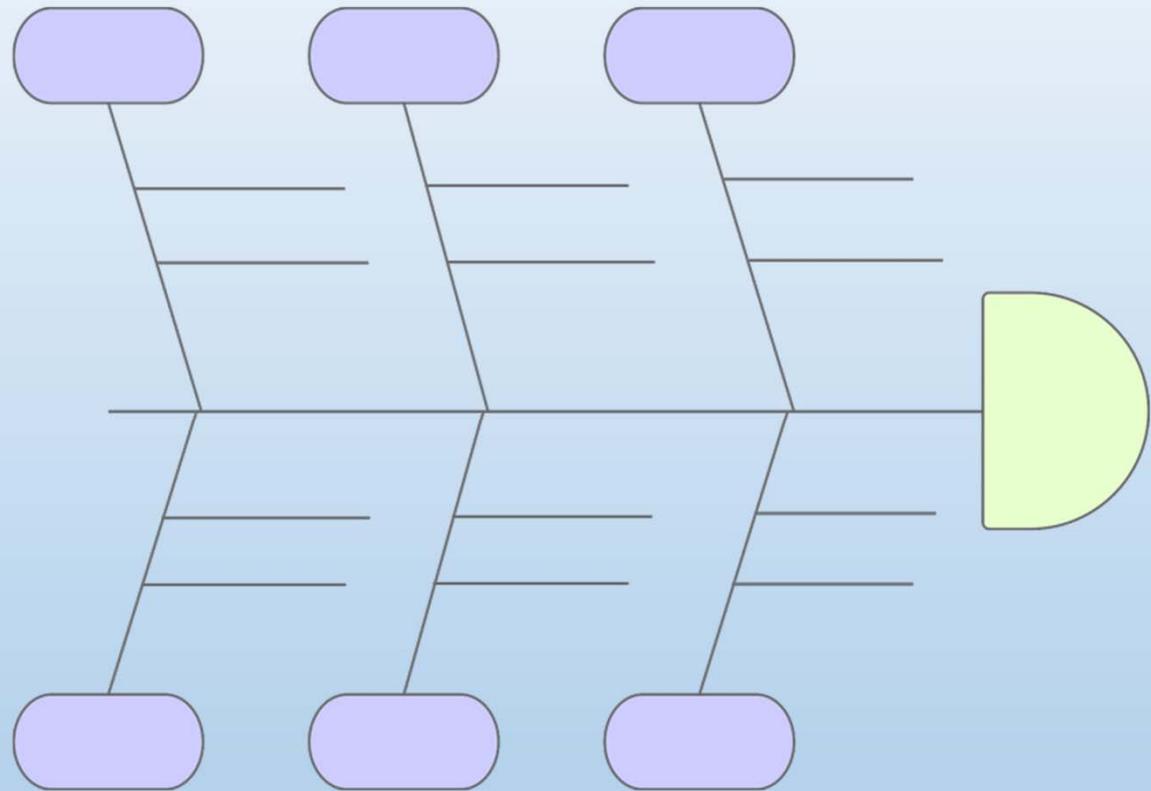
Realize that the most obvious reason may not be the real reason an event occurred

Sort root cause(s) and contributing factors into categories to aid the identification of improvement actions

RCA should focus on systems and processes, not on individuals

Fishbone Cause and Effect Tool

Equipment
Process
People
Materials
Environment
Management



Five Whys Tool

Continue the process until the root cause is uncovered

There may be more than one root cause

Ask “If this were removed, could the problem have been prevented?” If the answer is “yes”, you have found a root cause

5 Whys Investigation Worksheet

Define the Problem:

1.

→ Why is that?
↓

2.

→ Why is that?
↓

3.

→ Why is that?
↓

4.

→ Why is that?
↓

5.

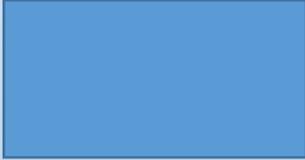
Caution: If your last answer is something you cannot control, go back to previous answer.

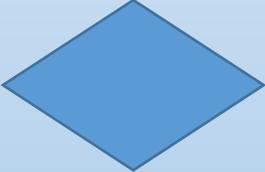
Solution:

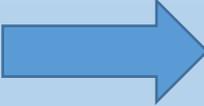
Flow Charting

Flowcharts are diagrams that use shapes to show the types and flow of steps in a process. The shapes represent different types of steps or actions

beginning and end of a process = 

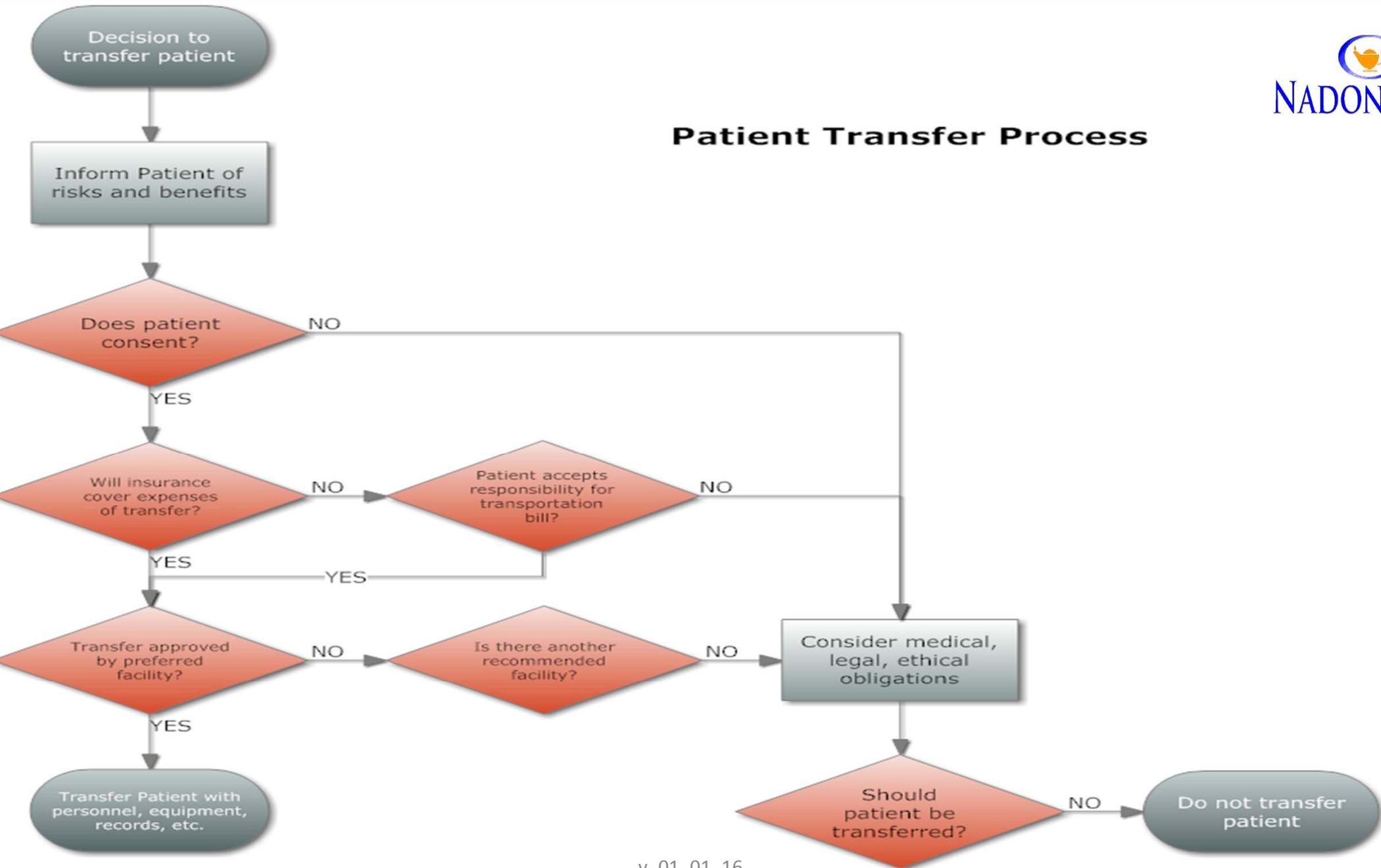
task or activity performed in the process = 

decision point (yes/no) = 

direction of flow = 

data = 

Patient Transfer Process



Resources



NADONA QAPI Tool Kit available at www.NADONA.org

QAPI at a Glance

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/QAPIAtaGlance.pdf>

The CMS QAPI Guide: What You Need to Know – A companion to QAPI at a Glance – includes 12 Action Steps to QAPI and useful tools

<http://www.ohiokepro.com/shopping/pdfs/8772.pdf>

Questions?



Boot Camp for Nurse Leaders

Risk Management

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NADONALTY

Learning Objectives



Describe a process for identifying and ranking risk in order to prioritize prevention and reduction responses

Explain the HHS Active Shooter *Run, Hide, Fight Model*

List three duties of a Corporate Compliance Officer

Discuss two government sites for use in screening employees, contractors, and vendors

State the primary difference between an OIG audit and an OIG investigation

Nursing Home Litigation

- The best facilities have a 40% chance of being sued
- The worst facilities have a 47% chance of being sued
- The average provider paid \$2,030 per bed in 2015 for liability claims, and the average claim was \$218,000 (Myers, Provider Magazine, September 2015)



Elements of a Legal Claim

Duty – to provide competent medical care

Breach of duty - failing to act as a reasonably prudent person would do

Causation – actions or inactions causing an injury to a person by one who could reasonably have foreseen that the actions or inaction might cause an injury

Harm and damages – a person was harmed or injured as a result of another's actions or inactions, and a court is able to compensate the injured individual for damages



Legal Terms



Plaintiff – the party who initiates a lawsuit by filing a complaint

Defendant - person, company, etc., against whom a claim or charge is brought in court

Tort – a civil wrong or wrongful act, whether intentional or accidental from which injury occurs to another

Negligence – the doing or the not doing of an act which a reasonable person under similar circumstances would or would not do, and which act or failure to act is the cause of injury

Malpractice – breach by a medical professional of either a standard of care or a standard of conduct, resulting in injury to a patient

Assault – crime of trying or threatening to hurt someone physically

Battery – carrying out a threat of assault; intentional causation of harmful or offensive contact with another's person without consent

Managing Risk by Applying Legal Principles



A nurse can only perform a nursing intervention, even if beneficial, by first obtaining the resident's consent – lack of consent could result in a finding of professional misconduct or allegation of battery

Avoid defaming the character of another or causing loss of professional reputation. Accusations must be able to be proven.

- Slander - oral defamation in which someone tells one or more persons an untruth about another, which will harm the reputation of the person defamed
- Libel - defamation by written or printed words, pictures, or in any form other than by spoken words or gestures.

Document! Cases are created by what is not in the chart

Customer Service – The Best Strategy



Friends don't sue friends – so build relationships of trust with residents and family members

Tell residents and families what to expect from nursing home life, the progression of their disease, and the aging process

Families are more likely to sue over a fall or pressure ulcer if the food is cold, dentures get broken, and clothing is lost

Apologies go a long way – say you are sorry it happened

36 states have “I’m sorry” laws – they make the expression of empathy to a family inadmissible in court

In the “I’m sorry” states, tort claims fell by up to \$73,000 per case

States with Apology Laws

Arizona
California
Colorado
Connecticut
Delaware
Florida
Georgia
Hawaii
Idaho
Iowa
Indiana
Louisiana
Maine
Maryland
Massachusetts
Michigan
Missouri
Montana

Nebraska
New Hampshire
New Jersey
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wyoming

Understanding Risk Management

Risk - the possibility that something bad or unpleasant (such as an injury or a loss) will happen; someone or something that may cause something bad or unpleasant to occur (Merriam-Webster)

Risk management - the identification, assessment, and prioritization of risks followed by coordinated and economical application of resources to minimize, monitor, and control the probability and/or impact of unfortunate events or to maximize the realization of opportunities

The Two Dimensions of Risk

Probability - the degree of likelihood that something will go wrong

Impact - the negative consequences that occur if it does



Prioritizing Risk Reduction Efforts

1. Create a comprehensive list of likely risks that your department faces
2. Determine the likelihood of each risk occurring, and assign a risk rating from 1 to 10, with 1 being extremely unlikely to occur and 10 being extremely likely to occur
3. Estimate the impact of the risk by using the 1 to 10 scale, with 1 representing little impact and 10 representing a catastrophic impact
4. Plot the ratings on a Risk Impact/Probability Chart
5. Develop a response to each risk according to the position on the chart

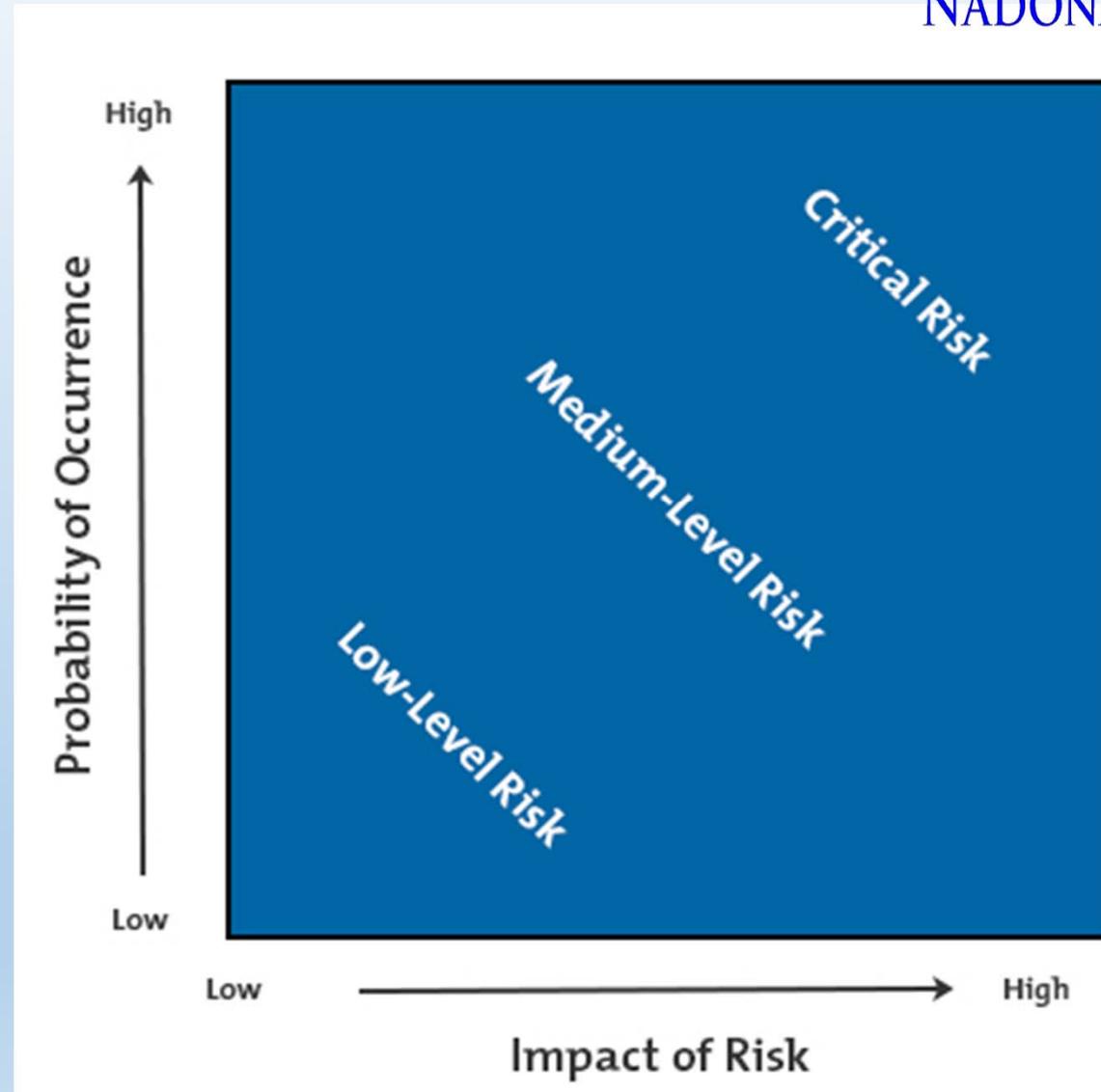
(MindTools.com)

Ranking Risk

High-probability/high impact risks are most critical and should be addressed immediately

Low-probability/high impact and high-probability/low impact risks are next in priority

Low-probability/low-impact risks can often be ignored, but not if they involve potential for injury or loss of human life



Examples of Common Risk Areas

Resident Related

- Falls
- Unsafe smoking
- Unsafe wandering & elopement
- Entrapment
- Burns
 - Tap water too hot
 - Unsafe handling of hot beverages
- Resident to resident altercations
- Chemical or electrical exposure
- Choking

Staff Related

- Medication errors
 - Coumadin
 - Insulin/blood glucose
- Unnecessary medications
- Missed lab tests
- Skin breakdown
- Unplanned weight loss
- Malnutrition/dehydration
- Constipation/impaction
- Equipment failure

Risk Management Program



Includes activities that monitor and manage actual and potential risks

Teamwork is focused on

- ensuring resident and staff safety
- responding to concerns and incidents
- addressing resident and family complaints
- complying with federal and state regulations

Goals are to

- protect the organization's interests
- improve quality of resident care
- control or eliminate negative events

Entrapment Assessment

Guidance for Industry and FDA
Staff Hospital Bed System
Dimensional and Assessment
Guidance to Reduce Entrapment

[http://www.fda.gov/downloads/
MedicalDevices/DeviceRegulation
andGuidance/GuidanceDocument
/ucm072729.pdf](http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocument/ucm072729.pdf)



Take Incidents and Reporting Seriously



- Describe the circumstances
- List date, time, location, shift, unit
- Obtain witness, staff, and resident accounts
- Interventions taken immediately to care for the resident
- Notifications made
- Resident symptoms/activity prior to the incident
- Vital signs and observations
- Associated injuries/medical problems
- Contributing environmental hazards or faulty
- Corrective actions taken to reduce likelihood of another incident

Key Points for an Incident Report

Information must be legible

No opinions, assumptions, or speculation

Rather than saying equipment was faulty, say, “Resident has been placed in another bed until bed can be inspected by maintenance.”

State facts objectively – do not assign blame

Complete entire report during the shift on which it occurred

Avoid leaving blanks that may be questioned later

Include names of witnesses

Incident Aftercare

- Update the resident's care plan
- Include the information in your shift report
- Provide follow-up care and monitoring
- Initiate needed forms: vital signs monitoring, neuro checks, etc.
- Document post-injury assessment, intervention, monitoring
- Monitor until resolved and resident is stable for >24 hours
- Document final note in medical record



Analyzing Incidents

Develop a timeline

Involve nurses on the unit in incident investigations

Identify precipitating and contributory factors

Look for patterns

Maintain a record of the investigation and outcome

Develop an action plan, implement it, and monitor

Keep a quality assurance log to identify trends so risk of recurrence can be anticipated and avoided

Public Image When an Accident Occurs



Immediately: inform the administrator and begin the investigation

Notify legal counsel and the insurance carrier

Implement a plan for dealing with publicity

Avoid making assumptions, promises or accepting blame

Apologize without admitting guilt

One spokesperson should keep one family member informed

Remove faulty equipment - get it checked by an independent, knowledgeable person

Protect confidential information – only those who must know should

Provide emotional support through social services, pastoral care, debriefings, etc., depending on the circumstance

Occupational Safety and Health Administration



Healthcare workers have some of the highest rates of non-fatal occupational injuries and illnesses of any industry

Safe Patient Handling brochure

<https://www.osha.gov/Publications/OSHA3708.pdf>

Occupational Hazards in Long Term Care Nursing Home eTool

<https://www.osha.gov/SLTC/etools/nursinghome/index.html>

Workplace Violence Prevention and Related Goals

<https://www.osha.gov/Publications/OSHA3828.pdf>

Inspection Guidance for Inpatient Healthcare Settings

https://www.osha.gov/dep/enforcement/inpatient_insp_06252015.htm

Blood Borne Pathogens

<https://www.osha.gov/SLTC/bloodbornepathogens/>

HHS Active Shooter Guidelines



Train employees to identify individuals who may be on a trajectory to commit a violent act.

Designate a preferred method for reporting active shooter incidents, including informing all those at the HCF or who may be entering the building.

Develop an evacuation policy and procedure and teach it to staff.

Designate and practice emergency escape procedures and route assignments (e.g., floor plans, safe areas).

Teach lockdown procedures for individual units, offices, and buildings.

Arrange in advance for integration between the internal incident commander & external incident commander.

Post emergency response information for agencies and hospitals (e.g. name, telephone number, and distance from the location)

13 Dead – 4 wounded
April 3, 2009

A gunman invaded an immigration services center in downtown Binghamton, N.Y., during citizenship classes on Friday and shot 13 people to death and critically wounded 4 others before killing himself in a paroxysm of violence that turned a quiet civic setting into scenes of carnage and chaos.



Run, Hide, Fight Model

If it is safe to do so, the first course of action that should be taken is to run

If running is not a safe option, staff should be trained to hide in as safe a place as possible where the walls might be thicker and have fewer windows. For patients that cannot “run” because of mobility issues, hiding may be their only option

If neither running nor hiding is a safe option, as a last resort and when confronted by the shooter, adults in immediate danger should consider trying to disrupt or incapacitate the shooter by using aggressive force and items in their environment, such as fire extinguishers, chairs, etc.

<http://www.phe.gov/preparedness/planning/documents/active-shooter-planning-eop2014.pdf>

Emergency Preparedness

Develop Emergency Plan: Gather all available relevant information for developing the emergency plan. This includes, but is not limited to:

- Copies of any state and local emergency planning regulations or requirements
- Facility personnel names and contact information
- Contact information of local and state emergency managers
- A facility organization chart
- Building construction and Life Safety systems information
- Specific information about the characteristics and needs of the individuals for whom care is provided

Obtain the CMS Revised Emergency Checklist - S&C-14-12-ALL

September 6, 2011
Tropical Storm Lee
- Owego NY



The Office of Inspector General (OIG) Scope

Corporate Compliance Programs were voluntary until the Affordable Care Act of 2010 was passed by Congress, at which time they became mandatory

CMS published new regulations for Corporate Compliance in the Proposed Rule of July 16, 2015



Corporate Compliance – Seven Elements



Development and distribution of written standards of conduct

Designation of a compliance officer and compliance committee

Development and implementation of regular, effective education and training programs for all employees

Creation and maintenance of effective communication strategies

- Anonymity
- Whistle-blower protection

Use of audits and other risk evaluation techniques

Development of policies and procedures that address non-employment or retention of excluded individuals or entities

Prompt response and investigation when offenses are detected

DIG Identified Areas of Risk

Quality of care

Residents rights

Employee screening

Vendor relationships

Physician services

Submission of accurate claims

Cost reporting

Anti-supplementation (billing above the set Medicare and Medicaid payment rate)

Medicare D

Screening

Screen all employees, contractors, and vendors against the OIG List of Excluded Individuals and Entities (LEIE) at

<https://exclusions.oig.hhs.gov>

- Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP)

Check employees, contractors, and vendors against the OIG list of debarred contractors at <https://www.sam.gov/portal/SAM/##11> and select SEARCH tab

- SAM (System for Award Management) combines data from the Central Contractor Registration, Federal Register, Online Representations and Certification Applications, and the Excluded Parties List System

Code of Conduct

A written statement of the fundamental principles and values of the organization and the structure that guides operations

Cover general principles that apply to all employees in simple, easy-to-understand language

All employees should be trained in the meaning of the content

Employees should sign a copy to be placed in their employee file showing that they understand and will follow it

Contractors should also receive a copy

Compliance with the code of conduct is everyone's responsibility

Compliance Officer

Can be a full time position or one of many duties for the assigned person depending on the size of the facility

Must be a high level employee with authority and access to the CEO

Should provide a report to the governing body regularly

Must be a person who is approachable by all levels of employees and will listen to their concerns, no matter how small they may seem

Compliance Committee

Made up of a mix of individuals so that all segments of organizational life are represented

Have all committee members sign statements certifying that they:

- are willing to perform the assigned tasks
- will maintain confidentiality of information accessed during committee operations, not only during their tenure on the committee, but also after their term or employment ends

OIG Audits and Investigations

OIG audit – evaluation by an OIG auditor(s) to examine facility Medicare/Medicaid performance or financial management systems

OIG investigation – examination by an OIG auditor(s) to resolve complaints or allegations of violations of law, policy, or regulation

Payment violations are most often the results of errors

Auditors are authorized to access all records, including electronic records contained in facility computers

Common OIG Findings

Up-coding – using a billing code that is not the best descriptor of the service a resident needs in order to maximize reimbursement

- Example – providing more therapy than a person really needs in order to achieve a higher RUG category

RUG Creep – the MDS is fraudulently completed to place the resident into a higher RUG category

- Example - recording more minutes than the resident actually used

False Claims Act

Enacted in 1863 by a Congress concerned that suppliers of goods to the Union Army during the Civil War were defrauding the Army

Sets forth liability for anyone violating the False Claims Act by

- Submitting a false claim to the government OR
- Causing the submission of a false claim OR
- Making a false statement or submitting a false document about a claim

A person is considered to have knowledge of a false claim if he/she

- Has actual knowledge
- Deliberately ignored the truth or false information
- Recklessly disregarded the truth or false information

OIG Hotline

Post in a prominent place the

- HHS-OIG Hotline telephone number: 1-800-HHS-TIPS (1-800-477-8477) Fax: 1-800-223-8164
- HHS mailing address

U.S. Department of Health and Human Services
Office of Inspector General
ATTN: OIG HOTLINE OPERATIONS
PO Box 23489
Washington DC 20026

§483.85 Compliance & Ethics Program

One year after the effective date of the final rule, the operating organization for each facility must have in operation a compliance and ethics program. Required components include:

Written compliance and ethics standards, policies, and procedures that are reasonably capable of reducing the prospect of criminal, civil and administrative violations, and promoting quality of care

Designation of an appropriate compliance and ethics program contact to whom suspected violations can be reported, and an alternate method of reporting anonymously and without fear of retribution

Assignment of specific high-level individuals of the operating organization with overall responsibility to oversee the corporate compliance and ethics program

§483.85 Compliance & Ethics Program (cont'd)

Sufficient resources and authority to the specific individuals

Care to avoid delegating discretionary authority to individuals who have a propensity to engage in criminal, civil, or administrative violations

Effectively communicate the standards, policies, and procedures to the entire staff, contractors, and volunteers

Consistent enforcement of the standards, policies and procedures through appropriate disciplinary mechanisms

Discipline of individuals responsible for failure to detect and report a violation to the compliance and ethics program contact

Take reasonable steps to respond to a violation and prevent recurrence

OIG Corporate Compliance Guidelines



OIG Compliance Program Guidance for Nursing Facilities – available at
<http://oig.hhs.gov/authorities/docs/cpgnf.pdf>

OIG Supplemental Compliance Program Guidance for Nursing
Facilities – available at
http://oig.hhs.gov/fraud/docs/complianceguidance/nhg_fr.pdf



Boot Camp for Nurse Leaders

Strategic Planning

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NADONA Director of Education



NADONALTO

Learning Objectives

Discuss the steps to follow in creating a strategic plan

Define 3 key budgeting terms

Explain 4 cost categories used when developing a budget

Differentiate between traditional and zero-based budgeting practices

What Is Strategic Planning?

The process of setting future goals and outlining a course of action to achieve those goals

Looking ahead to formulate objectives the facility would like to achieve three, five, or even 10 years into the future

Both short term and long term planning are essential functions



Steps to Strategic Planning



1. Conduct external and internal audits to get a clear picture of your competition and your organization's competencies and specialties
2. Focus on where you want to take your department/facility over time by defining your mission (markets, customers, products, etc.) and vision (conceptualization of what your department/facility's future should or could be)
3. From this analysis, determine the priority issues and goals - the strategic plan should focus on these
4. Determine who is accountable, the strategies, action plans, and budgets, and how you will allocate resources to achieve the goals
5. To ensure the plan performs as designed, hold regularly scheduled formal reviews of the process and refine as necessary

Budgeting

A budget is a written financial plan that is formalized in an objective, quantifiable format

It lists goals and states them in monetary terms that can be considered benchmarks

It covers a specific period, usually the fiscal year (12 month period) for a healthcare facility

A budget must be based on realistic expenditures and well thought out projections

Staffing and Census Budgets



- Not all budgets address revenue, expenses, cash, or capital costs
- Budgets can address hours of nursing care for each resident, or hours for ancillary personnel such as dietary or housekeeping staff
- Census is frequently a driving force in determining labor costs, which are frequently 70% or more of the total cost of running a facility
- Managing staffing daily is essential so that payroll expenses stay on budget
- Staffing should be directly linked to census and the acuity level of the residents

The Operating Budget

Typically the budget is divided into revenues and expenses

- A fiscal plan for revenue centers includes areas of facility operations that will generate income or revenue
- A fiscal plan for cost or expense centers includes areas that will generate facility expenses

The operating budget must be monitored with actual numbers compared to budgeted numbers

Whenever the actual exceeds the budgeted numbers, investigation must take place to determine why and to decide how to bring the budget back under control

Capital Budget

Capital budgeting is planning ahead so that depreciated equipment and other high cost items can be purchased or replaced

Capital budgets are reviewed on an annual basis as part of the budget planning process

Examples of capital equipment planning: replacing parallel bars in the therapy department, adding a new air conditioning system or elevator, or acquiring new state-of-the-art lifts for safely moving residents

Capital budgeting relies on astute forecasting abilities and communication between department heads and the administrator about future needs

Capital budgets must be prioritized based on need and the amount of working capital that is projected to be available throughout the year

Cost Categories

Fixed costs – do not vary, such as a building lease or rental agreements and utilities that must be paid regardless of census

Variable costs – fluctuate directly with productive activity and census – food costs are an example

Semi variable costs – vary based on management decisions, such as advertising

Direct costs – specific to a service or product, such as purchasing equipment or labor costs

Indirect costs – not directly attached to a specific department, such as the cost of absenteeism, turnover, and recruiting

Overhead costs – the cost of items needed to run a business

Necessary and Unnecessary Costs

Necessary costs are essential and contribute to an increase in profitability for the company

Unnecessary costs are costs that when eliminated help increase a facility's margin of profit

Managers must distinguish between necessary and unnecessary costs when building a budget



Controllable vs Uncontrollable Expenses



Controllable expenses - costs that a facility has the power to change, such as payroll and supplies

- Staffing and supplies are two of the largest budget items and are considered controllable

Uncontrollable expenses - costs a facility incurs regardless of the operational decisions it makes.

- Unavoidable costs include rent, office supplies, and some taxes

Budgeting Processes

Zero-based budgeting

- a method for preparing cash flow budgets and operating plans in which you start from scratch every year with no preauthorized funds
- requires each activity to be justified on the basis of cost-benefit analysis with no balance carried forward

Traditional or incremental budgeting

- a method in which past revenue and expenditure trends are assumed to continue and are used to build the new budget

Budget Responsibilities for the DON

Personnel

- Wages, salaries, benefits, overtime, orientation, education

Other expenses

- Supplies – medical and non-medical, minor equipment, linen, purchased services



The Budget Cycle



Questions



Dr. Earl on Leadership Evaluation

In order to continually improve my presentations I'd appreciate your feedback. Please take a few minutes and return this form to me. Thank You!

Name: _____ Position: _____

Organization: _____ Website: _____

Phone: _____ Email: _____

Contact me, I would like you to speak to my organization.

Contact me, I would like you to find out more about executive coaching.

- The most valuable idea (s) I heard:

- The action step(s) I am committed to taking as a result of this presentation:

- How it will benefit my team or organization:

- Other comments:

I know of a business or organization that would benefit from this presentation:

Contact Name: _____ Position: _____

Organization: _____ Website: _____

Phone: _____ Email: _____

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Leadership Intensive: Catching, Motivating & Retaining Your Best Employees



Presented by

Earl L. Suttle, Ph.D.

Leadership Success International, LLC

Follow me on  @drearlspearls





Ain't no mountain high enough

Ain't no valley low enough

Ain't no river wide enough

Encourage



Wow!

Celebration Stories

Allow team members to share stories

Overview

- How to utilize celebrations to increase work performance
- How to continue growing as leaders
- Increasing your personal power
- How to find the needs of your people
- Understanding people
- 10 Pearls for Motivating and Energizing Your Staff

**What do the most
talented employees
need from the
workplace?**

“Great Managers and Great Leaders”



It's a Whole New World

“It's a whole new world out there, with new playing fields, rules and players. Your choice is to either learn the new game or continue to be the very best player in a game that is no longer being played.”

Larry Wilson

A Definition of Leadership

“The ability to influence the attitudes, thoughts, beliefs and behaviors of others.”

“The winning leaders of today are those who develop other leaders the fastest.”



**Great leaders are
never satisfied
with their
current level of
performance.**

How Should We Grow?

5 Major Leadership Growth Areas

1. People Skills _____
2. Attitude Skills _____
3. Communication Skills _____
4. Leadership Skills _____
5. Personal Growth Skills _____

What is your Personal Growth Plan?

Dr. Earl's Personal Growth Plan

- Listen one hour per day to CDs in car
- Read something inspirational each morning
- Attend at least one workshop or seminar per month
- Each week speak to a motivational person
- Put something in my journal several times per week
- Attend monthly meeting with my dream circle group

H

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Ways to Raise Positivity and Happiness Levels



within your organization

Understanding People

(How to Have More Personal Power With People)

1. People are _____

2. People want to _____

3. People need to be _____

4. People want _____



“I know God will not give me more than I can handle. I just wish He didn't trust me with so much.”

Mother Teresa

**“Great leaders
read people
before they
lead people.”**

4 Styles

- **Style 1** Want to talk about it, learn what the team has to say
- **Style 2** Want to hear about it, hear what the experts have to say and be accurate
- **Style 3** Want to get to the bottom line, get it done the right way
- **Style 4** Want to see the big picture, be innovative and have fun with it all

Style 1

Loyalist (Dove)

Get Along People



Strengths:

- Service oriented
- Great listeners
- Team player
- Likes hearing about and expressing feelings
- Trainable
- Slow to change

Value: relationships and cooperation

Style 2

Analyst (Owl)

Get it Right People

Strengths:

- Loves to be right and hates to be wrong
- Likes to take time to get things done
- Likes to work with others who appreciate their abilities
- Wise
- Self control and cautious
- Prefers analysis over emotion
- Slow to change



Value: problem solving, order and quality

Style 3

Pragmatist (Eagle)

Get it Done People



Strengths:

- Loves to take action
- Enjoys the leadership role
- Loves to start projects and complete them
- Direct and to the point
- Loves change

Value: progress and productivity

Style 4

Populist (Peacock)

Get the Big Picture People

Strengths:

- Loves to respond to intellectual challenges
- Sociable, outgoing
- Optimistic and energetic
- Likes to be the center of things
- Have great ideas

Value: innovation and creativity



**Loyalist
(Dove)**



**Get Along
People**



**Analyst
(Owl)**

**Get It Right
People**



**Pragmatist
(Eagle)**

**Get It Done
People**



Populist

(Peacock)

**Get The Big
Picture People**

**“Dr. Earl’s
10 Pearls
for Motivating and
Energizing Your
Staff”**

“To lead people, walk behind them. When the best leader’s work is done, the people say, ‘We did it ourselves’.”

Chinese Philosopher

True leaders
don’t create
followers.
they create
more leaders!

You were dynamic!

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Earl Suttle



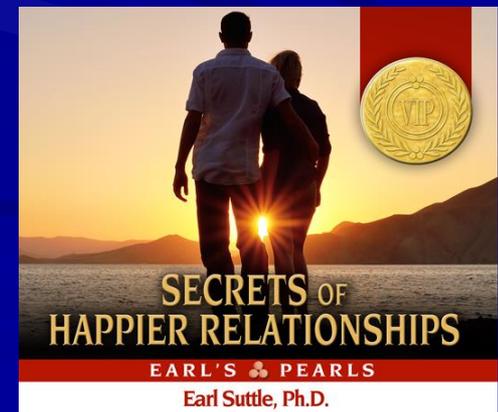
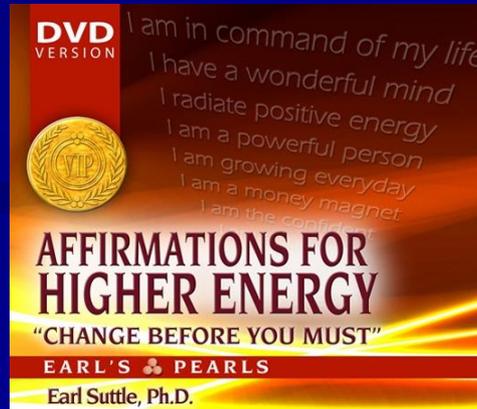
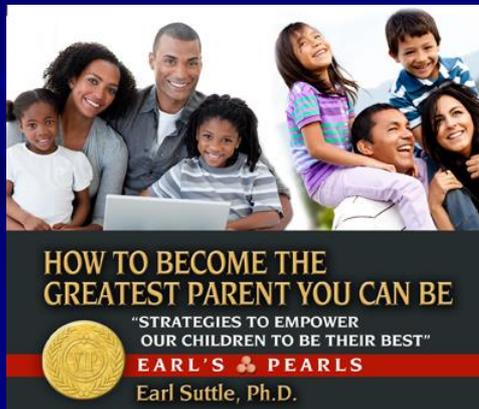
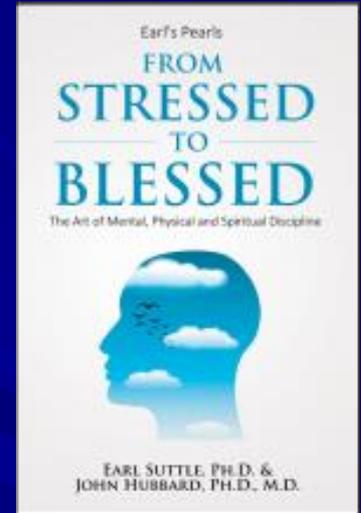
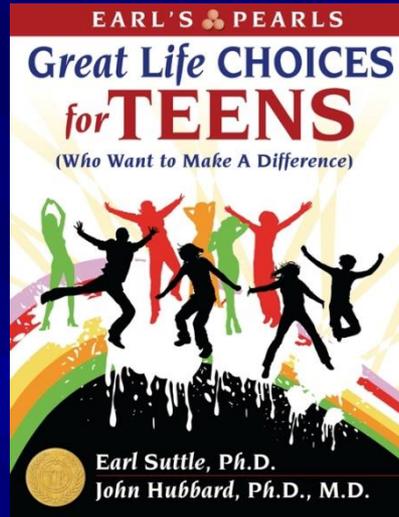
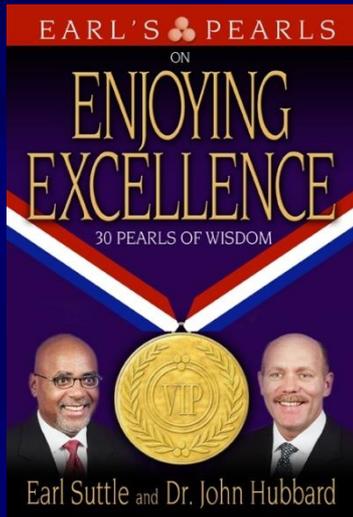
Earl Suttle



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FADONA'S
Carrying the Torch
of Leadership

Leadership Intensive: Catching, Motivating & Retaining Your Best Employees

Presented by

Earl L. Suttle, Ph.D.
Chairman & CEO

Leadership Success International, LLC

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Key Ideas About Celebrations

Leader's role in a celebration is to listen and encourage the performers to re-live their accomplishment – not tell the performers what they did.

People should tell their stories. Frequently they are the only one who knows the details of what caused the success that is being celebrated.

You need to give people a chance to tell you how hard it was, how long it took, how they would have never been able to complete it without the help of others.

In successful celebrations, leaders ask employees to share what they've done.

The leaders can ask questions such as:

- How did you do that?
- What did you do?
- How did you figure it out?
- Who helped you?
- How hard was it?

Benefits:

1. Creates an atmosphere more meaningful to the one sharing the celebration story.
2. Gives voice to everybody and keeps a collective memory alive.
3. Give people meaning to their jobs.
4. Creates inspiration and purpose.
5. Develops a strong us feeling.
6. Gets people in touch with people's humanity.
7. Creates a sense of community important for the company's long-term survival.
8. Encourages dialogue.
9. Creates a WOW! Experience within the organization.
10. Raises standards.
11. Provides training for others.



Dr. Earl's Personal Growth Plan

- 1. Every day I listen to CDs on motivation, leadership, communication, finance or relationships (at least one hour). I listen while driving my car. (I turn my car into a mobile classroom.)**
- 2. Every morning I read something inspirational and motivational (i.e. inspirational book, daily meditation book or one chapter of a new book).**
- 3. Every morning, I do a brisk walk to start my day off with a victory! Yes, I take a CD player or iPod with me each time and listen while I walk.**
- 4. I attend at least one workshop or seminar per month. If I can't get to a workshop, I go to the bookstore and purchase a book (that's my workshop for the month).**
- 5. Each week I speak to a motivational person.**
- 6. I file something important in my journal each day.**
- 7. I expand on dream ideas to put in my dream book or journal.**
- 8. I attend at least two times per month meetings with my dream circle group.**



Personal Growth Plan

1. _____

2. _____

3. _____

4. _____



H

H

H

How to have more personal power with people

1. People are _____
2. People want to be _____
3. People need to be _____
4. People want _____

“Great leaders read people before they lead people.”



MOTIVATING AND REWARDING THE FOUR STYLES

(Loyalist) Dove Value: relationships and cooperation

- Enjoys personal attention
- Likes being helpful to people
- Likes hearing about and expressing feelings
- Shows compassion for others

You can reward Loyalist by:

- Praising a good effort
- Allowing opportunities for them to help
- Permitting creative and expressive activities
- Sharing the personal part of your reactions with the person

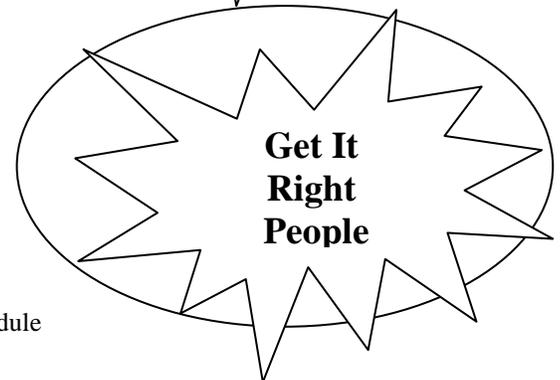


(Analyst) Owl Value: problem solving, order, accuracy and quality

- Loves to be right and hates to be wrong
- Likes to take their time to get things done
- Like to work with others who appreciate their capabilities

You can reward Analyst by:

- Praising neatness and problem solving abilities
- Praising completeness of work
- Praising thoroughness and detail
- Allowing them to set their own learning and testing schedule



(Pragmatist) Eagle Value: progress and productivity

- Loves to take action
- Enjoys taking a leadership role
- Likes to start new projects

You can reward Pragmatist by:

- Permitting activities after completion of quiet work
- Praising completion of successful projects
- Providing opportunities for leadership roles
- Giving specific, active responsibilities

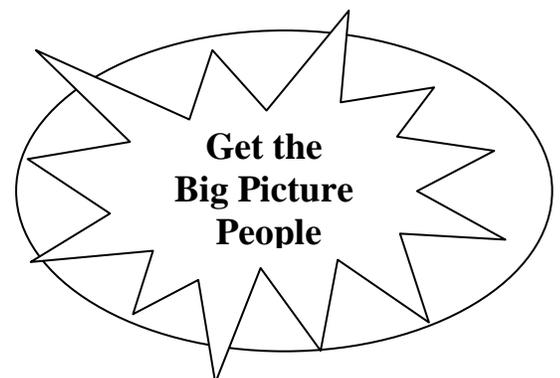


(Populist) Peacock Value: progress and productivity

- Loves to respond to an intellectual challenge
- Likes to think about important goals and issues
- Needs time and breathing space
- Have great ideas

You can reward Populist by:

- Valuing their creativity by encouraging it in discussion
- Allowing thinking time
- Designing their own goals/objectives
- Putting them with people who will value their skills
- Risk taking abilities



Dr. Earl's 10 Pearls for Motivating and Energizing Your Staff

“To lead others is to lead yourself first.”

“If you want to build your teams – Celebrate more.” Earl Suttle, Ph.D.

1. People stay where they are _____ not tolerated. *“Employee of the moment”*
2. People do what they _____. *“5M’s”*
3. Asking the _____ helps you build the _____. *“Wandering Around Questions”*
4. Know what they _____ and how they would like to _____ and _____. *“Menu of Rewards”*
5. _____ them before you _____ them.
6. Treat your team as a _____.
7. Focus on their _____. *“7 Employee Hot Buttons”*
8. _____ to them. *“2 Ideas to Make Department Better”*
9. Develop _____ systems for your employees.
10. Have them _____ you.

“To lead people, walk behind them. When the best leaders work is done, the people say, “We did it ourselves”. Chinese Philosopher



Leadership Empowerment Motivational Tools

1. Celebrations – Allowing them time to share their customer service celebration stories.
2. W4C – walk the four corners and asking questions (Wandering Around Questions).
3. Menu of rewards – find out how they want to be recognized and rewarded if they did something great on their job.
4. Seven Employee Hot Buttons.
5. Mistake of the Month Award – (You winning the award the first two months.)
6. Green, Red, Purple (let them influence you)
 1. Green – what I need to keep on doing
 2. Red – what I need to stop doing
 3. Purple – what I need to start doing
7. Find demotivators and designing a plan to solve them.
8. Focus on their strengths – catch them doing something right. (Employee of the moment reward)
9. Stand Up Fridays (what’s the most exceptional thing you have done this week to add value to the organization that you are proud of?) What exceptional thing do you plan to accomplish this week?
10. Thank You cards – sent home.
11. Listening better to employees – at the end of the week, what are the 3 things you learned from listening to your people?
12. Personalize reward system.
13. Two ideas that could make the department or organization better.
14. Employee survey.
15. Coaches Score Card.
16. 5 Step Leadership Model Survey.
17. Mini 360 Supervisor/Manager Evaluation
18. 5 Step Framework for Leadership Model
19. What Motivates Me Survey
20. I Appreciate You Exercise

Circle at least 2 motivational tools you plan to take action on when you return to your department. How are you going to hold yourself accountable to do at least one of them?



Coaching with Confidence

Problem Focus Questions

1. What's wrong?
2. Why do you have this problem?
3. Whose fault is it?
4. How long has this been going on?
5. What is this costing you?
6. Why haven't you overcome it?
7. Don't you know better than this?
8. What's your problem?
9. Why are you so far behind the other team?
10. Why aren't you keeping up?
11. I don't understand why you haven't finished that report yet?
12. I want you to apologize to marketing about your mistake.

Solution Focus Questions

1. What do you really, really want?
2. What is working well with it?
3. When do you want it?
4. What else?
5. What needs to happen to get it?
6. What resources are available to you?
7. What are your specific objectives?
8. How can you best use each resource?
9. What kind of support do you need?
10. What can you begin doing now to get what you want?
11. How can I be most helpful to you in what you would like to do in that area?
12. What could you do more of, better or differently to improve in those areas?
13. What can I do to make your job easier?
14. Let's discuss possible solutions to that with the marketing department, ok?



Recommended Leadership Books

- | | |
|--|---------------------------------------|
| 1. Earl's Pearls on Enjoying Excellence | Earl L. Suttle |
| 2. Stressed to Blessed (available summer 2016) | Earl L. Suttle |
| 3. Who Moved My Cheese | Spencer Johnson |
| 4. Enlightened Leadership | Ed Oakley and
Doug Krug |
| 5. It's Your Ship, It's Our Ship | Captain Michael Abrashoff |
| 6. CEO Tools | Kraig Kramers |
| 7. Developing the Leader Within
25 Ways to Win with People | John Maxwell |
| 8. The Art of Managing People | Philip Hunsaker
Anthony Alessandra |
| 9. The Fred Factor | Mark Sanborn |
| 10. Helping People Win at Work | Ken Blanchard
Garry Ridge |
| 11. 1001 Ways to Take Initiative at Work | Bob Nelson |
| 12. Common Sense Management &
Motivation for the Real World | Roy Holmes |
| 13. How to Motivate Every Employee | Ann Bruce |
| 14. The Leader Who Had No Title | Robin Sharma |
| 15. Top Ten Mistakes Leaders Make | Hans Finzel |
| 16. How Full is Your Bucket? Positive Strategies
for Work and Life. | Tom Rath |
| 17. Personality Plus – How to Understand Others | Florence Littauer |
| 18. Success Magazine | |
| 19. Greatness Guide | Robin Sharma |
| 20. How to Win Friends and Influence People | Dale Carnegie |





Achieving Success in Reducing Inappropriate Use of Antipsychotic Medication in Patients with Dementia

Deborah Afasano, BSN, RNC, CDONA, HCRM
Vice President of Clinical Services, Avante Group

Rick Foley, PharmD, CPh, CGP, FASCP, BCPP
Clinical Professor of Geriatrics, University of Florida College of Pharmacy
President, Florida Chapter - American Society of Consultant Pharmacists

Amy J. Osborn, NHA, PMP
Executive Director, Health Services Advisory Group, HSAG

Polly Weaver, BS
Assistant Deputy Secretary of Health Quality Assurance, Agency for Health Care Administration, AHCA

March 22, 2016



OBJECTIVES



- Examine the potentially inappropriate use of antipsychotic medication in patients with dementia
- Analyze de-identified cases of inappropriate use of antipsychotic medication in patients with dementia through root cause analysis
- Integrate interventions to reduce the inappropriate use of antipsychotic drugs in patients with dementia





NATIONAL PARTNERSHIP TO IMPROVE DEMENTIA CARE

Amy Osborn NHA, PMP; Executive Director, Health Services Advisory Group, HSAG





GOAL FOR 2016: 30% OR GREATER REDUCTION

What is your current rate?

What percentage reduction has your center achieved?



Let's Compare!

Partnership Results – Florida



- Q4 2011 – Florida 24.5
- Q3 2015 – Florida 17.59

Reduction of 28.2%

- Q4 2011 – Nation 23.9
- Q3 2015 – Nation 17.43

Reduction of 27.0%

- Florida Ranks – 35 of 51
- Florida Ranks – 35 of 51





ACHIEVING SUCCESS IN REDUCING INAPPROPRIATE USE OF ANTIPSYCHOTIC MEDICATIONS IN PATIENTS WITH DEMENTIA – SURVEY PERSPECTIVE

Polly Weaver, Assistant Deputy Secretary, Health Quality Assurance
Agency for Health Care Administration



F309

§483.25 Quality of Care



Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Surveyors use this guidance for a resident with dementia. If the resident is receiving one or more psychopharmacological agents, also review the guidance at F329, Unnecessary Drugs.



F309

§483.25 Quality of Care – continued



- If a concern is identified during a survey that an antipsychotic medication may potentially be administered for discipline, convenience and/or is not being used to treat a medical symptom, consider reviewing F222 - 483.3(a) Restraints, for the right to be free from any chemical restraints.



F309

§483.25 Quality of Care – continued



- Facilities should be able to identify how they have involved residents/families in discussions about potential approaches to address behaviors.
- Potential risks and benefits of a psychopharmacological medication (e.g., FDA black box warnings).



F309

§483.25 Quality of Care – continued



- It is expected that the resident's record reflects the implementation of a systematic care processes:
- Recognition and Assessment (MDS)
- Cause Identification and Diagnosis;
- Development of Care Plan;
- Individualized Approaches and Treatment;
- Monitoring, Follow-up and Oversight; and
- Quality Assessment and Assurance (QAA).



F329

§483.25(l) Unnecessary Drugs



- Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
 - In excessive dose (including duplicate therapy); or
 - For excessive duration; or
 - Without adequate monitoring; or
 - Without adequate indications for its use; or
 - In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
 - Any combinations of the reasons above.



§483.25(I) Unnecessary Drugs – continued



- Antipsychotic Drugs.

Based on a comprehensive assessment of a resident, the facility must ensure that:

- Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and
- Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.



F329

§483.25(I) Unnecessary Drugs – continued



- The intent of this requirement is that each resident's entire drug/medication regimen be managed and monitored to achieve the following goals:
 - Promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, as identified by the resident and/or representative(s) in collaboration with the attending physician and facility staff;
 - Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed condition(s);



F329 Unnecessary drugs – continued



Goals continued

- Non-pharmacological interventions (such as behavioral interventions) are considered and used when indicated, instead of, or in addition to, medication;
- Clinically significant adverse consequences are minimized; and
- The potential contribution of the medication regimen to an unanticipated decline or newly emerging or worsening symptom is recognized and evaluated, and the regimen is modified when appropriate.



F329 Unnecessary drugs – continued



The surveyor's review of medication use is not intended to constitute the practice of medicine. However, surveyors are expected to investigate the basis for decisions and interventions affecting residents.

NOTE: This guidance applies to all categories of medications including antipsychotic medications.



Unnecessary Medications Investigative Protocol



Surveyors use this protocol during every initial and standard survey. In addition, this protocol may be used on revisits or abbreviated survey (complaint investigation) as necessary.



F329

Investigative Protocol



Not intended to direct medication therapy. However, surveyors are expected to review factors related to the implementation, use, and monitoring of medications.

Was there a failure in the care process related to considering and acting upon an adverse consequence related to medications?

The surveyor may need to contact the attending physician or consultant pharmacist regarding questions related to the medication regimen.



F329 Investigative Protocol ~ Determination of Compliance



Six aspects to the unnecessary medication requirement.

The facility must assure medication therapy is based upon:

1. An adequate indication for use;
2. Use of the appropriate dose;
3. Provision of behavioral interventions and gradual dose reduction for individuals receiving antipsychotics (unless clinically contraindicated) in an effort to reduce or discontinue the medication;



F329 Investigative Protocol ~

Determination of Compliance – continued



4. Use for the appropriate duration.
5. Adequate monitoring to determine whether therapeutic goals are being met and to detect the emergence or presence of adverse consequences; and
6. Reduction of dose or discontinuation of the medication in the presence of adverse consequences, as indicated.



Tapering of a Medication Dose/Gradual Dose Reduction (GDR)



- **Considerations Specific to Antipsychotics.** The facility **must** attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated.
- **Tapering Considerations Specific to Sedatives/Hypnotics.** For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the facility **should** attempt to taper the medication quarterly unless clinically contraindicated.



Tapering/GDR – continued



- **Considerations Specific to Psychopharmacological Medications (Other Than Antipsychotics and Sedatives/Hypnotics).** During the first year in which a resident is admitted on a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), or after the facility has initiated such medication, the facility **should** attempt to taper the medication during at least two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a tapering should be attempted annually, unless clinically contraindicated.





IMPROVING CARE AND QUALITY OF LIFE FOR PATIENTS WITH DEMENTIA IN LONG- TERM CARE

Rick Foley, PharmD, CPh, CGP, FASCP, BCPP

Consultant Pharmacist – Omnicare

Clinical Professor of Geriatrics – UF College of Pharmacy

President – Florida Chapter American Society of Consultant Pharm



The Pharmacist's Perspective



- First do no harm
- The regulations
- Trends in the field
- Recognizing prescribing patterns that lead to antipsychotic (AP) use



First Do No Harm



- EPS
 - 1 in 10 pts taking olanzapine, 1 in 20 w/ risperidone
- CVA
 - 1 in 34 patients taking risperidone
- During 10-12 week trials, 1 out of every 100 patients taking an atypical AP died



- Conventional and atypical antipsychotics appear to increase the risk of hospitalization for femur fracture in a population of institutionalized elderly patients. These medications should be used with caution, especially among patients with a high risk of falls
Journal of Clinical Psychiatry 2007, 68 (6): 929-34

- Atypical antipsychotic drugs may be associated with a small increased risk for death compared with placebo *JAMA: 2005 October 19, 294 (15): 1934-43*

increase the risk of hospitalization

- The studies have also shown, however, a greater risk of mortality and adverse cerebrovascular events with several of these agents than with placebo in individuals with dementia [Harv Rev Psychiatry](#). 2005 Nov-Dec;13(6):340-51.

increased risk for death

- Our findings suggest that many older people with Alzheimer's dementia and NPS can be withdrawn from chronic antipsychotic medication without detrimental effects on their behavior *Neuropsychopharmacology*, 2008 April; 33(5): 957–970; doi:10.1038/sj.npp.1301492

greater risk of mortality

- Among patients continuing phase 1 treatment at 12 weeks, there were no significant differences between antipsychotics and placebo on cognition, functioning, care needs, or quality of life *American Journal of Psychiatry* 2008, 165 (7): 844-54



F329 – Unnecessary Drugs



- New concept – May 2013
 - “Individualized, person-centered approaches that may help reduce potentially distressing or harmful behaviors and promote improved functional abilities and quality of life for residents”
 - Bottom line – AP’s can only be used after ALL other causes of behavior have been ruled out



F329 - continued



- Requirements when using APs
 - Diagnosis
 - Target behaviors – quantitative documentation each shift; specific guidance on TBs
 - Dose limitations, unless documented rationale is present
 - Daily monitoring of side effects
 - Assessment of movement side effects at least every 6 months
 - GDR twice within first year, in two separate quarters and separated by at least 1 month
 - Contraindication requires significant rationale



Quarter 3 - 2015 CMS



- **National Partnership for the Treatment of Dementia**
 - Initial antipsychotic use reduction set at 15% for 2012
 - National average reduction 15.1%
 - New goal set to reduce by 25% by the end of 2015 and 30% by the end of 2016
 - Florida -28.2% (Q3 2015)
 - Reinforces the concept of non-pharmacologic approaches
 - ALL regions achieved goal
- **As of Q3-2015, Florida ranks 35th of 50 states + D.C. at 17.6%; Louisiana 51st at 22.3%**
 - Hawaii ranked #1 at 7.6% with a 38.7% reduction



Trends In The Field



- Microdosing of Quetiapine
 - Potent binding and antagonism of H¹ and α-1 receptors
 - Sedation, orthostasis, weight gain
 - Side effects may be enhanced at low doses
 - 25mg QHS for “dementia” -- *sleep?*
 - 25mg QHS and my patient is falling!
- Blanket contraindication statements
 - Preprinted progress notes
- Staff pushback on GDR despite documentation



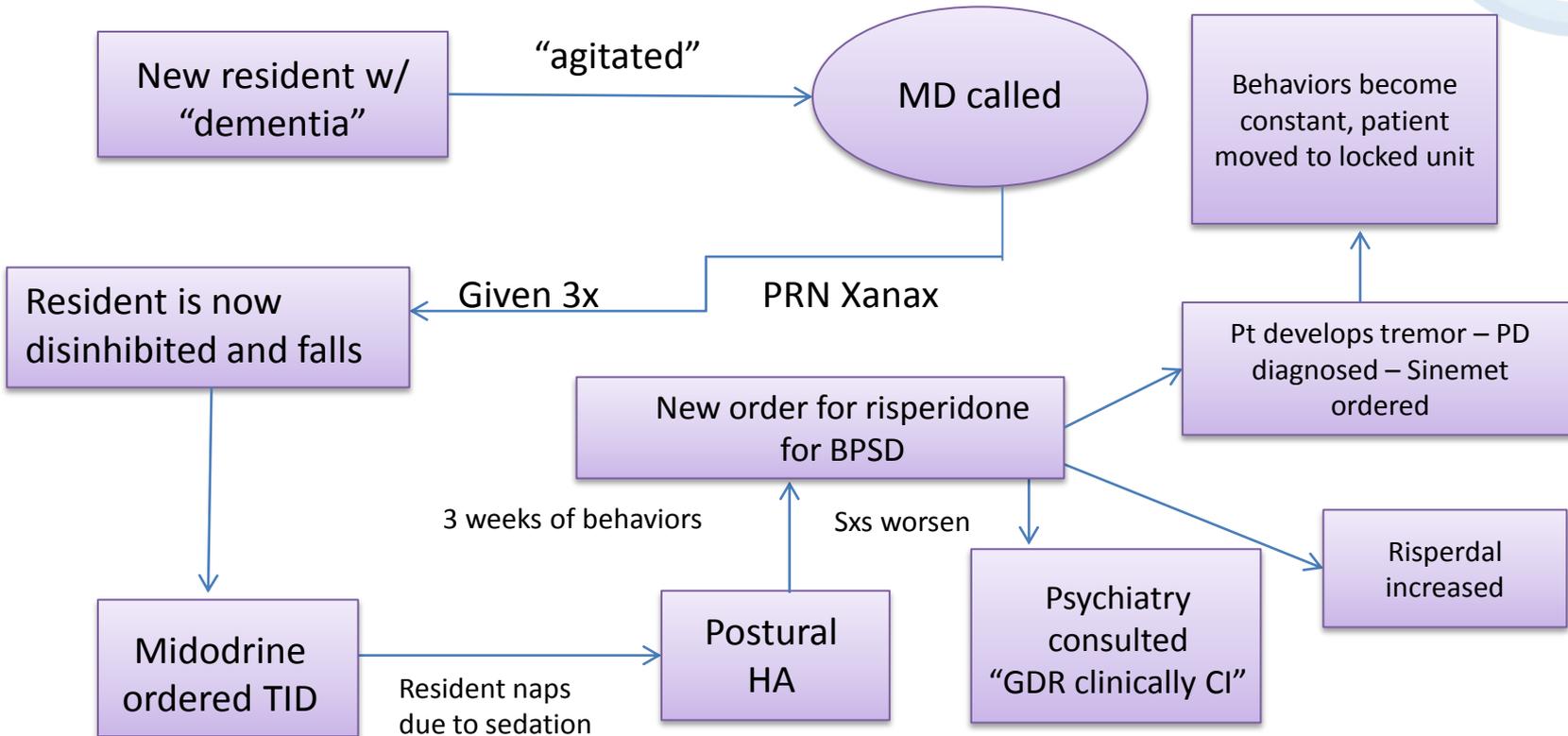
Other Patterns



- Justifying admission orders
 - Newly diagnosed schizophrenia...at age 95?
 - Benadryl from home? Must be itching, at HS
- Disregard of the geriatric demographic
- Ignoring ongoing prescribing cascades



Prescribing Cascades and Aps: A Real World Example



Prescribing Cascades – Common Issues



- Limited information for practitioners
- Assuming disease manifestation
- Broad strokes with “blank check” orders
- Underestimation of drugs’ side effect potential and severity – anticholinergic load
- Overestimation of efficacy of “behavior” meds prescribed
- Lack of “zero-budgeting” drug regimen evaluation

A method of **prescribing** in which **medications** must be justified for each new period. Zero-based budgeting starts from a “zero base” and every **treatment, goal of therapy, and expected and realistic patient-focused outcome**, is analyzed for its **appropriateness and risk-benefit profile**



Non Pharmacologic Approaches To Behaviors



- Avoid confrontation
- Remove environmental triggers
- Create calm, quiet environment (offer gentle help)
- Structure daily routine
- Address pain, discomfort
- Use aromatherapy
- Use scheduled or prompted toileting





CASE STUDY



Case Study

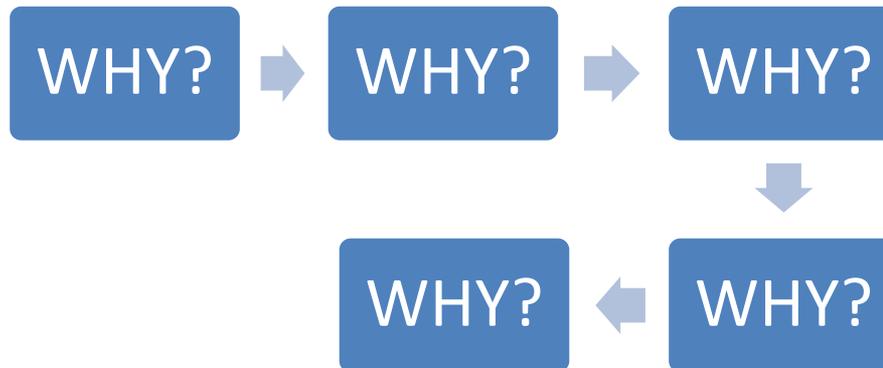
- An 88 year old female was admitted to the nursing home on November 1, 2015, after hospitalization for a hip fracture sustained while showering at home.
- In addition to the history of hip fracture, this resident has a diagnosis of dementia.
- The resident's daughter had indicated that her mother had a significant fear of showers (as a result of the fall) and that a bed bath was the preferred method of bathing.
- Social worker's notes, nurse's notes and the care plan all included information that the family had reported on admission that the resident was very fearful of showers and that bed baths were the preferred method of bathing.

Case Study

- When the resident initially moved into the facility, the daughter insisted on bathing her mother. In early **December**, due to schedule challenges, the daughter informed the facility that she would no longer be able to do this and the **facility staff** would need to provide the bed baths.
- During a care plan meeting on February 5, 2016, the daughter realizes that facility staff had been attempting to shower this resident.
- The daughter becomes irate during the meeting and later that evening emails a complaint to the State Survey Agency.

Case Study

- What is the failure noted in this scenario?



- What should the facility have done after the care plan meeting?

Case Study

- A complaint investigation is initiated by the State Agency on February 9, 2016.
- During the investigation, the surveyor observes staff giving this resident a shower during which, the resident exhibits substantial fear and distress
 - Screaming
 - Crying
 - Trying to bite and scratch staff
 - Repeatedly trying to get out of the shower chair
- A second staff member responds to call for assistance and proceeds to help with completion of the resident's shower
- The surveyor intervenes on behalf of the resident so that the shower is discontinued.
- On closer examination of the resident, the surveyor notes bruising of the resident's arms and buttocks.

Case Study

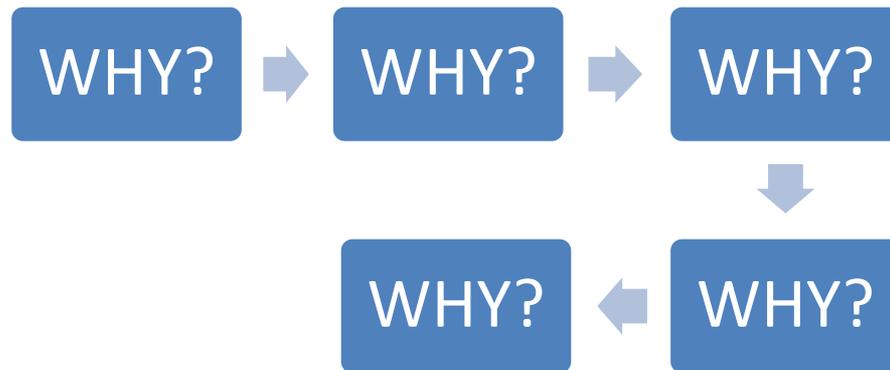
- For the remainder of the day, Ms. Osborne exhibits significant psychological distress.
- No licensed staff intervened to assess the resident's situation and the care plan was not consulted.
- On interview, staff indicated this resident always cries out during her shower and attributed this behavior to her dementia; the staff member stressed to the surveyor that she recognized the need for a good shower for all residents she cared for.
- When asked about the bruising, the staff member stated that this resident had very thin skin and bruised easily.

Case Study

- Review of the residents' records and staff interviews indicated that the facility staff had been showering this resident three times weekly since early December.
- While continuing record reviews, observations, and interviews as part of the investigation of concerns related to this resident, the surveyor noted that the resident had an order of Risperdal 3mg, PRN for agitation.
- On interview, staff stated that this medication was only given when the resident became so agitated that no other interventions would calm her which typically was only after she was showered.

Case Study

- What are some of the systems issues that have failed in this facility?



Case Study

- Direct care staff were not aware of the resident's fear of showers.
- No alternative routines or approaches were considered.
- Staff failed to reassess and investigate the causes of the behavior.
- Staff were not trained in identification of issues that should be brought to the QAA committee.
- This situation was not brought to the QAA committee.

Case Study

- No evidence of physician involvement in creating or updating the dementia care policies.
- The facility has not conducted any investigation after these incidents.
- There is no attempt on the part of nursing home staff to identify the underlying cause of the distress.
- Staff were not trained in dementia care practices.

Case Study – Potential Noncompliance

- F155—The Right to Refuse Treatment
 - Failed to assess the reason the resident was combative (refusing) the bathing attempts and offer alternative options.
- F157—Notification of Change
 - Failed to notify physician of change in behavior.
- F222—Restraints
 - Failed to define therapeutic indication of psychoactive medication; medication used for convenience.
- F223 – Abuse
 - The resident has the right to be free from abuse.
- F224 – Staff treatment of Residents
 - Failed to provide goods and services necessary to avoid physical harm
- F225 – Failed to investigate potential abuse
- F272—Comprehensive Assessments
 - Failed to conduct comprehensive assessments of psychosocial well-being, mood symptoms, potential risk for accidents.

Case Study – Potential Noncompliance

- F282—Provide Services per Care Plan
 - Failed to provide bathing method per care plan.
- F309—Quality of Care
 - Failed to recognize and assess factors placing the resident at risk for significant psychological distress.
- F319—Mental/Psychosocial Difficulties
 - Failed to provide services to address behaviors resulting from bathing attempts.
- F329—Unnecessary Drugs
 - Failed to define therapeutic indication of psychoactive medication.
- F428—Drug Regimen Review
 - Failed to identify therapeutic intent for psychoactive medication.
- F501— Medical Director
 - Failed to identify, evaluate and address health care issues related to the quality of care including appropriate bathing opportunities or implement an effective system to monitor the performance and practices of care givers.
- F520— Quality Assessment and Assurance
 - Failed to include known concerns in the QAA process for development of an effective action plan.

Case Study – Potential Noncompliance

- Can you think of any other deficiencies not listed?
- What would be the highest Severity and Scope for these deficiencies?

Case Study

- What are interventions that should have been considered for this resident?



STORY OF GERALDINE

Lost and then found

Deborah Afasano, BSN, RNC, CDONA, HCRM; Vice President of Clinical Services, Avante Group



Ask



- When using a psychotropic to manage **behavioral self expression** ask:
 - “How will the drug solve the problem?” ...
 - “Will it lower dopamine levels that will make a wandering person not want to stop exploring the environment, or make a person that hates being bathed suddenly find it enjoyable? Not Likely! (Dementia Without Drugs)



Strategies – Behavioral Manifestations

What and when is it is happening?



- Yelling and screaming:
 - What is the cause?
 - Over stimulation, lack of adequate attention, pain, hunger, fear, depression?
- Catastrophic reactions: Anger, fighting, mood changes
 - May be related to apraxia (loss of motor skills) cognitive loss, and overwhelming demands.
 - Catastrophic reactions occur most often during the morning hours when daily care activities is the highest



Agitation...



- Suggests unmet needs
- Have we ruled out pain, cold, thirst, hunger, frustration, the need to toilet?
- What is the person trying to say?
- Do you see pacing, pounding, picking, repetition, and restlessness?
- Is the restless motor agitation a med side effect?



Resisting Care



- Is the resident feeling rushed or treated impersonally?
- Is pain a factor?
- Cognitive loss, loss of skills and refusal to cooperate may replace feelings of powerlessness with a sense of control



Sleep Patterns



- Sleep Hygiene
 - How have they slept in past (Routines)
 - What makes sleep easy/difficult
 - What has worked in past?
 - What happens at night?



Verbal Aggression



- Arguing, cursing, threatening... May be a form of resisting care and an outlet for anger and frustration
- Cognitive loss = loss of impulse control



Wandering



- May be related to stress, boredom, pain, and/or the need to urinate or defecate
- This may suggest under activity and stimulation seeking behavior, or being lost in the environment
- Wandering may be related to following the behavior of another, or side effects of antipsychotics
- Acting out prior life experiences (Going to the bus stop?) **What happens at change of shift?**



Evaluation of Environment



- Consider environmental factors and triggers
 - Heat
 - Cold
 - Noises (Bed alarms, staff at night)
 - Quiet
 - Lighting
 - Size of bed
 - New environment
 - Care giver approaches



Evaluation of Medical Conditions



- Involve Physicians/Extenders/Consultants: Medical Evaluation
- **What is happening Internally?**
 - Pain
 - Depression
 - Dehydration
 - Infection
 - Exacerbation of a chronic condition (CHF)
 - Drugs/Medication side effects
 - Delirium
 - Use of chemicals/substance abuse
 - Recent surgery requiring anesthesia
 - Metabolic/electrolyte disturbances
 - Hypoxemia/Blood Sugar...



Evaluate Physical & Psychological Needs

- Thirst
- Hunger
- Constipation
- Urinary retention, frequency or discomfort
- Fatigue, Insomnia, Anxiety
- Fear, Depression. Boredom
- Privacy/Choice
- Impaired speech/communication: Missing glasses/hearing aides? Visual changes?
- Change from normal routines



Evaluate Changes in Eating Behaviors



- Relearn eating behavior –hand over hand (Dining With Friends, Alzheimer's Association)
- Dentures in place, mouth care
- Wear glasses/hearing aids
- Staff consistency: Plan for the needs
- Watch the environment: hot, cold, noisy, crowded
- Encourage family to bring favorite foods
- Administer analgesics/antiemetic's before meals
- Focus on quality versus quantity – caregiver impatience



Five Basic Goals of Care



1. Patient feels safe –protected (observe body language, facial expressions)
2. Patient to feel physically comfortable
3. Experience a sense of control –dignity, freedom
4. Minimize stress/environmental distractions
5. Pleasant experience



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Considerations for Implementing a Facility Quality Forum

1. Secure the commitment of the facility administrator, director of nursing, medical director.
 - ✓ The administrative team ultimately makes the difference in implementing changes in policy and practice and creating a culture of communication, collaboration and opportunity
 - ✓ A commitment requires the endorsement of the facility and corporate support, (as warranted). It requires that the administration endorse and support those charged with planning changes.
 - ✓ The purpose of Quality Forums will be to influence quality of care for residents, work together with shared visions, embrace collaborative communication, and offer support for stakeholders and recipients of LTC outcomes.
 - ✓ Introduce the concept of a shared forum structure as part of Resident Council, Family Council, Employee meetings, and facility newsletters.
2. Create a small—and enthusiastic “Facility Quality Forum. Make this a component of the facility Risk and QAA and QAPI Program.
3. Under the direction of the Administrator, appoint multidisciplinary and **transdisciplinary** representatives of the staff, residents, families, and interested stakeholders.
 - ✓ Key Point: Secure diverse representation and feedback from varied perspectives that cross departmental lines.
 - ✓ Who would be good representatives? What about the president of the resident council?
 - ✓ Who will be champions for change?
 - ✓ Remember, some of the members can be added ad hoc as the team establishes goals and establishes priorities.
 - ✓ Create a Mission Statement: Why this is important? The elements of the statement are, “**Who we are, what we do, and why we do it.**”
 - ✓ Create a reasonable meeting schedule, timeline, budget, (printing, education, etc.).
 - ✓ Provide internal support and allow for the provision of meeting space and time for the team to convene on a regular schedule.

4. Team Tasks: Schedule a meeting of representatives to discuss: **“Where are our gaps in service? What are the opportunities?”**
5. Discuss current strengths, weaknesses, opportunities, and threats.
 - ✓ Identify resources and capabilities, e.g. strengths within the current staffing plan.
 - ✓ What would be needed to facilitate organizational depth?
 - ✓ Evaluate the status of current written processes and procedures.
 - ✓ Evaluate opportunities identified through data such as Grievance reports, resident council minutes, customer satisfaction surveys, and formal/informal feedback.
 - ✓ Review related regulatory requirements to determine clinical areas for focus such as:
 - i. **First impressions and transitions of care**
 - ii. Pain Management
 - iii. End of life Care
 - iv. Restorative Care
 - v. Nutrition
 - vi. ADL Management
 - vii. Psychosocial needs and Mental Health
 - viii. Mobility
 - ix. Disease Management
 - x. Behavioral Management
 - xi. Management of High Risk populations
 - ✓ **Solicit current opinions, comments and/or concerns regarding gaps in service, opportunities, and resident definitions of quality of life from the perspective of Physical, Mental, and Psychosocial Well Being.**
 - ✓ Are all appropriate disciplines involved?
 - ✓ Identify educational resources.

Key Point: The initial brainstorming session may reveal many needs and changes that will require prioritization. Begin with quick-start projects that will generate enthusiasm, rather than an arduous project like rewriting all the policies at once.

- ✓ Based on the internal assessment, identify priority aspects of staffing to be improved over the next quarter.
- ✓ Stay realistic while raising the bar of expectations one notch at a time.

- ✓ Appoint a leader for team discussions. Select a representative that can work with the team to provide team reports to the Risk/QAA/QAPI committees
 - ✓ Communicate team goals via story boards, education, newsletters, or alternate means. Assign a recorder for the forums.
 - ✓ Keep systems simple
 - ✓ Identify support documents and resource lists: Policies and procedures, educational resources and tools.
6. Include "infrastructure" changes whenever possible. Train and Educate about the Facility Quality Forum.
7. Plan.

Key Point: Involving Forum representation is an ongoing initiative. “Promoting Quality through Sharing”, should be ongoing theme within your facility.

- ✓ In order to sustain the gain, Identify for each targeted area, specific changes that may be needed in the institutional structure. These infrastructure changes may include such things as:
 - a) Revising the orientation and in service programs, to include staff, residents, families.
 - b) Ensure the Forum discussion is forwarded to the facility QAA/QAPI as necessary to mobilize changes.
 - c) Revisions to facility P&P, education, staff/resident and family orientation, on an ongoing basis.
 - i. Updating job descriptions/roles
 - ii. Review and update education to match new job descriptions and role expansion.
 - iii. Identifying tools
 - iv. Communication strategies, etc.
 - d) Adopt Forum reviews as part of Risk/QA meetings;
 - e) Utilize information from other RM and Quality sources to identify new themes for Forum discussion.
 - f) Promote knowledge through newsletters, bulletin boards, internal postings, contests, etc.
 - g) Tracking and trending clinical indicators and matching changing acuities to staff skills and staffing patterns.
8. Take incremental steps, but make them visible.

Key Point: Though the steps may be small, they should be visible and measurable. Once actions are chosen, develop a QI monitoring tool to identify areas of success or opportunities for improvement.

- ✓ Recognize success and give credit to those making a difference, however minor. As soon as one change is working, choose another. The impact of these changes will grow over time.
- ✓ Example: Create a storyboard to QA/QI action steps, e.g. “Promoting Relationships at the beginning of Care Transitions”

9. Establish responsibilities and a time-line.

Key Point: For each goal or action, decide who is responsible, how often and in what context they will visit the issue, and the date for expected completion or reevaluation.

- ✓ Allow a reasonable amount of time to affect change. Prioritize tasks based on identification of needs.

10. Collaborate with colleagues from other facilities and regions.

Key Point: Talking with others and sharing ideas, policies and educational programs will save countless hours and sustain creativity. Seek out or form regional networks for support. Who shares a vested interest in innovative staffing and workforce development?

- ✓ Quality Improvement is ongoing. Identify opportunities, applaud your successes, and sustain your gains.

Courtesy of:

Deborah Afasano, BSN, CDONA, CIC, ELNEC, C., HCRM
VP of Clinical Services
The Avante Group

Facility Quality Forum Guidelines
A Feedback and data PIP Tool for Residents, Families, and Staff
 Part of the Facility QAA/QI/QAPI

Suggested participants: Appoint a facilitator that is a trusted resource to residents, families, and staff. A social worker would be a suggested facilitator. It is suggested to have 2 residents, 2 families, 2 C.N.A. staff and a Charge Nurse. Keep the group to a small, workable number

Group Introduction: We are gathering information to guide culture change. This tool will guide feedback from the recipients of care, the consumers of care, and our wonderful workforce, the deliverers of care.

1. Explaining the three components of physical, mental, and psychosocial wellbeing:

“Facilities are guided by regulatory language that says residents have the right to maintain or attain the highest level of physical, mental, and psychosocial well being. In lay terms, that means that facilities are responsible for helping residents be the best they can be in regards to how they walk, move, care for yourself, use the bathroom, etc.”

2. Physical well-being, as defined by residents I have talked with is “body and soul harmony”. That has been explained as: “Getting help when you need it, doing what you can do, and having comfort”.

3. Mental well-being, in their terms, is “peace of mind, feeling safe and secure. A sense of well-being. Mental well being is the availability of resources for counseling and support, the ability to have access to care to meet individual needs.

4. Social well-being, as described by residents, is about friends, relationships, caring for others and being cared for. Social well being is involvement in “things you like to do”. Residents have noted the importance of establishing personal goals, and being seen as unique individuals.

Facilitator: Now I would like to hear from you, starting with talking about first impressions:
To Residents, and Families: What was your first impression of your facility?
(All) How could we do better?

HOW TO HANDLE FAMILIES FEELINGS OF LOSS

Based on the five stages of dying outlined in “*On Death and Dying*” by Dr. Elizabeth Kubler-Ross, psychiatrist and author.

FAMILY BEHAVIOR	STAGE	STAFF RESPONSE
The family says, “it cannot be true, this can’t be happening.” Their goals are often unrealistic.	DENIAL	Understand why the family is grasping at straws. Consider the losses they experience. Patience and willingness to talk are necessary.
The family says, “why me?” Deep anger follows. The families complain about almost everything and envy those who have a normal lifestyle.	ANGER	Consider the family is Angry over the loss of family life, home, work and play, as they know it. Respond with Understanding and respect; Do not return anger.
The family says, “I’ll keep my family members here if You do what you are Supposed to do.	BARGAINING	Identify the family’s expectations and personal agenda and include them in The resident’s plan of care.
The family begins to mourn the loss of their relationship as it previously existed.	DEPRESSION	Give family members time to express grief, sorrow, guilt and feelings of loss.
Family may start to refer to the facility as HOME .	ACCEPTANCE	Work with the family to make the resident’s environment homelike. Include the family in facility planning and the resident’s plan of care.



HEAR THEIR HEARTS

*Through our doors come a lot of lifetimes,
Fathers, Mothers, and those held dear,
Families cling to each other like lifelines
Filled with anger . . . pain . . . and fear.*

*Hear their hearts, what they aren't saying,
Hear the words they'd like to share,
Be a part of the prayers they are praying,
Show the families how much we care!!*

*Guilt and pain fill waking hours,
One day ends where another day starts,
Dreams have faded like wilted flowers,
Families bring us their broken hearts.*

*Families are strangers who arrive at our doorways,
With lives torn apart by the cruel hands of fate,
They seek out answers, and hope for better days,
Groping, and coping, praying it's not too late.*

*Many made promises and pledged love forever,
Swore not to leave a heart bound to their own,
Many discover they should never say never,
Now they are learning, to live life alone.*

*Families need time to explore painful feelings,
We need to explain what they don't understand,
Now is the time for their process of healing,
Now is the time to extend them a hand.*

*Families are fragile, they meet us as strangers,
The have hearts all in pieces, and we are the glue.
Trust is evasive as they face all life's dangers,
We must care for their loved one and care for them, too.*

*Seek out their hearts, hear what they aren't saying,
Help become the lifeline that brings them new hope,
Be the response to the prayers they've been praying,
We're their new family, and we'll help them cope.*

Title: New Resident and Family Formal Welcome and Facility Orientation

The intent of orientation is to establish proactive relationships, establish communication channels, foster trust, and provide an enhanced understanding of the facility mission and values, scope of service, and special programs.

Purpose: To provide resident and family orientation to the facility that:

- 1. Promotes self determination, participation and choice in selecting activities, schedules, and health care consistent with resident interest.**
- 2. Facilitates interaction and choices about aspects of life in the facility through an orientation to the internal facility community.**
- 3. Encourage choice about aspects of his/her life in the facility.**
- 4. Identifies a means for feedback on the admission process, and opportunities for improvement.**

Implementation Guidelines

- 1) Orientation for new residents and/or families is scheduled (day of facility choice) every month from ____ to _____. The location for orientation is: _____**
- 2) Information about the orientation will be provided in the admissions package, and reinforced by staff during their introductions to the new resident and family/RP.**
- 3) Social Services (or Activities) are responsible for sending out a notice of a formal orientation to new residents and families.**
- 4) Social Services, (or Activities) will provide department heads, and unit manager or Nursing Supervisor, with a list of residents and/or families that are planning on attending orientation**
- 5) Dietary will coordinate beverages and snacks for the meeting.**
- 6) The orientation will be interdisciplinary and will aim to include Nursing, Social Services, Dietary, and Activities. Other departments such as Therapy, Maintenance, Housekeeping, and administrative staff will participate or provide written information.**
- 7) Videos and pamphlets may be used to supplement departmental information.**
- 8) Shared information will include a brief description of departmental roles and responsibilities.**
- 9) Topics for consideration at orientation and future educational sessions for residents and/or families/RP's include:**
 - a) Identification of Departments Heads, their role, and how to contact them.**
Administrator/designee
 - b) Quality and Risk management- Nursing Administration or Administrator/designee**
 - i) Abuse Prevention (policy handouts)**
 - ii) RM/QA/QI /QAPI integration**
 - c) Advanced Care planning, Advance Directives, and Care plans - Social Services**
 - d) Grievance process, Family Council, QIS Interviews and/or Satisfaction Surveys, Support Groups, and Family Education- Social Services**

- e) **Ancillary Services: Transportation, Physician Consultations- Social Services (may be provided as handouts)**

 - f) **Nursing Services – Discussion of the Staffing Model, Primary assignments, and facility specific programs. Selected topics may also include a brief overview of:**
 - i) **Interact Integration: Stop and Watch**
 - ii) **Pain management**
 - iii) **Wound Team**
 - iv) **Fall Reduction**
 - v) **End of Life**
 - vi) **Quality measures**
 - g) **Activities- Resident Council, Facility events, special programs, volunteers**
 - h) **Dietary- Meal choices, snacks, substitutions, special programs**
 - i) **Therapy- PT,OT, and ST Services, referral process**
 - j) **Housekeeping and Maintenance Services**
 - i) **Personalizing your room**
 - ii) **Laundry services**
 - k) **Finances- billing, charges, Medicaid/Medicare**
 - l) **Questions and Answers**
 - 10) **Because time is limited, families and residents will be invited to arrange special times with individual departments as needed. The care plan schedule will be discussed, and residents and families will be encouraged to participate.**
 - 11) **Questions and Answers**
- .



COTLER HEALTHCARE
AND DEVELOPMENT

Mental Health Matters

Reducing Staff Stress: Person-Centered Approaches for Handling Difficult Residents

Nathalie de Fabrique, Psy.D.
Licensed Clinical Psychologist

Director of Clinical Services
COTLER HEALTHCARE

MAIN OBJECTIVES:

- Understanding Combative Behavior
- Providing alternatives to psychotropic medication
- Strategies to positively handle the combative resident
- Learning when to use behavioral interventions and supportive psychotherapy

DEFINITION

- Combative Behavior- any physically aggressive act that causes or intends to cause hurt or damage to a person or object
- Most aggressive/combative behavior occur in:
 - Dining Room
 - Bath/Shower
 - Toileting

CONTRIBUTING FACTORS TO AGGRESSIVE BEHAVIORS:

- Organic brain disorders (vascular dementia, stroke)
- Psychosocial causes
- Environmental causes

3 Key Components to Managing Combative Behavior:

- Assessment
- Diffuse/Minimize Combative Behavior
- Formulate a plan

WAYS TO PREVENT COMBATIVE BEHAVIOR

- General prevention techniques
- Strategies specifically geared toward dementia residents
- Preventing burnout in facility staff
- Offering counseling/therapy to residents who can benefit

Positive Communication

- State questions or ideas in positive terms
- Avoid baby talk
- Do not attempt to reason or apply logic

Behavioral Approaches

- Identify the Problem Behavior
- Identify the antecedents/trigger
- Identify the reinforcer of the problematic behavior
- Identify the desired behavior

Therapy for Dementia Residents

- Validation Therapy
 - Reflection
 - Redirection

Therapy for Dementia Residents, Cont'd

- Person-Centered Therapy
 - Decision-making power is in the hands of the individual
 - Help maintain personhood
 - Support individual while maximizing independence

Alternatives to Psychotropic Medication

- Ongoing supportive counseling
- Behavioral treatment plan
- Appropriate physical activity
- Environmental accommodations

THE END





COTLER HEALTHCARE
AND DEVELOPMENT

Mental Health Matters

Update on Pressure Ulcers: Utilizing an Interdisciplinary Approach to Pressure Ulcer Prevention

Charlene A. Demers
GNP-BC, CWOCN

Scope of the Issue

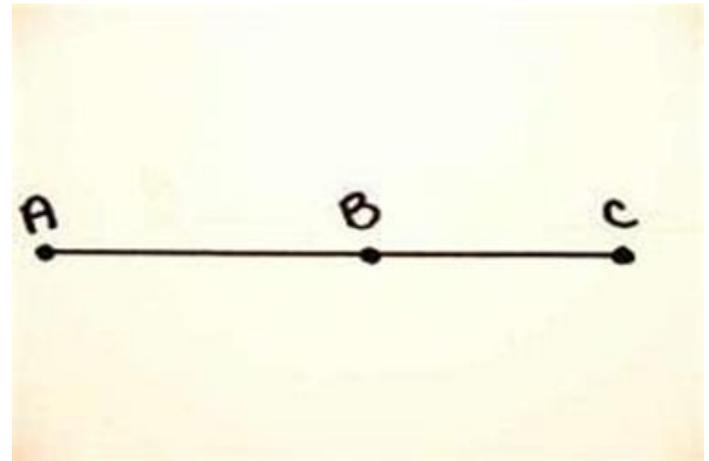
Cost

- \$9 billion to \$11 billion
- \$20,000-\$150,000 per ulcer



Incidence

- Home care – 17 percent
- Acute care – 38 percent
- Long Term Care – 24 percent



Why Team Approach?

- Institute of Medicine
 - Need for high functioning teams to address today's complex healthcare needs
- World Health Organization
 - Bringing together the skills of different individuals will strengthen the health care system and lead to improved outcomes



Why Team Approach?

- National Pressure Ulcer Advisory Panel
 - Nutrition, mobilization, medical devices
- American Medical Directors Association
 - An interdisciplinary team may help to ensure implementation of a consistent and appropriate process for pressure ulcer prevention



Making Teams Work

- Link to facility leadership
- Members with necessary expertise
- Clearly defined roles and responsibilities
- Access to resources needed to perform role



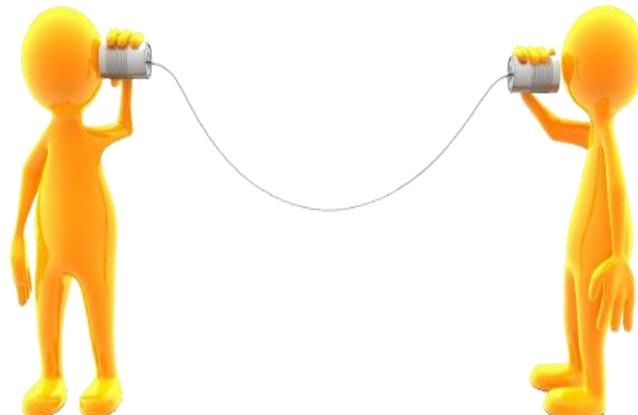
Making Teams Work

RESPECT	TRUST	HONESTY	DISCIPLINE
CREATIVITY	HUMILITY	CURIOSITY	INTEGRITY
ETHICS			



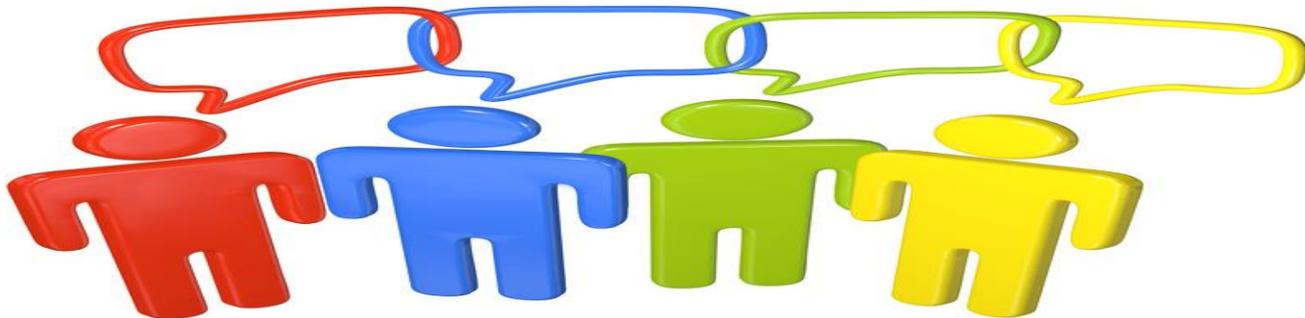
Making Teams Work

- Familiarity with services of other team members
- Communication structures to facilitate interdisciplinary communication
- Clearly established referral mechanism
- **Communication is paramount!**



Team Referral and Communication

- **Who? When?**
- Braden score 18? 12?
- Braden sub-scores?
 - Nutrition, mobility, activity scores
- PO intake? Lab values?
- Compromised skin integrity?



Clinical Team Roles

- Physician, NP, PA
- Nursing Staff
- Rehabilitation Therapists
- Nutritional Services
- Pharmacy



Physician, Nurse Practitioner, Physician Assistant

- Ordering of pressure redistribution surfaces?
- Modify, stabilize, or eliminate risk factors
 - Pain
 - Edema
 - Dysphagia
 - Spasticity
 - Incontinence
 - Poor perfusion and oxygenation

Physician, Nurse Practitioner, Physician Assistant

- National Pressure Ulcer Advisory Panel
 - “Use a high specification reactive foam mattress rather than a non high specification reactive foam mattress for all individuals assessed as being at risk for pressure ulcer development.” (Strength of Evidence = A)
 - “Use an active support surface (overlay or mattress) for individuals at higher risk of pressure ulcer development when frequent manual repositioning is not possible.” (Strength of Evidence = B)
 - “Ensure pressure ulcers are correctly differentiated from other skin injuries, particularly incontinence associated dermatitis or skin tears.” (Strength of Evidence = C)
 - National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Nursing

- Identifies those at risk and their risk level
- Performs skin assessments and skin inspections
- Initiates a plan of care for prevention
- **Evaluates the effectiveness of the interventions**
- **Modifies interventions and plan of care as needed**

Risk Assessment

- Conduct risk assessment ASAP but within 8 hours after admission (Strength of Evidence = C)
- Repeat risk assessment as often as required by the individual's acuity (Strength of Evidence = C)
- Conduct reassessment if there is any significant change in individual's condition (Strength of Evidence = C)
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Risk Factors

- Activity and Mobility
- Nutrition
- Skin Moisture
- Sensory Perception

- Current ulcer or previous ulcer
- Perfusion and oxygenation
- Increased body temperature
- Hematological measures
 - Albumin
 - Hemoglobin
 - C-reactive protein

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK				Date of Assessment			
Patient's Name	Evaluator's Name						
SENSORY PERCEPTION degree to which skin is exposed to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/3 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.			
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.			
ACTIVITY degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours			
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.			
NUTRITION usual food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/3 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.			
FRICTION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasmodic, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.				
				Total Score			

Skin Assessment

- Educate staff on how to conduct skin assessments/inspections (Strength of Evidence = B)
 - Blanchable vs. nonblanchable
 - Localized heat
 - Edema
 - Induration
 - Localized pain

– National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. *Pressure ulcers: Clinical practice guideline*. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.



Skin Assessment

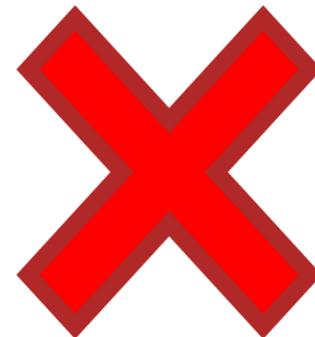
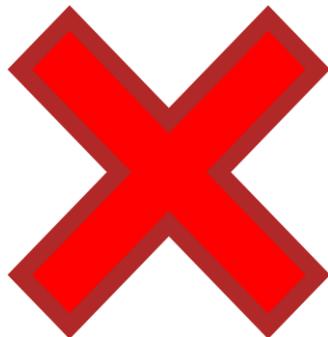
- Darkly pigmented skin
 - Skin temperature
 - Edema
 - Change in tissue consistency
 - National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.



Preventive Skin Care

- Use a pH balanced skin cleanser
- Protect skin from exposure to excessive moisture with a barrier product
- Use a skin moisturizer to hydrate dry skin to reduce skin damage

- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.



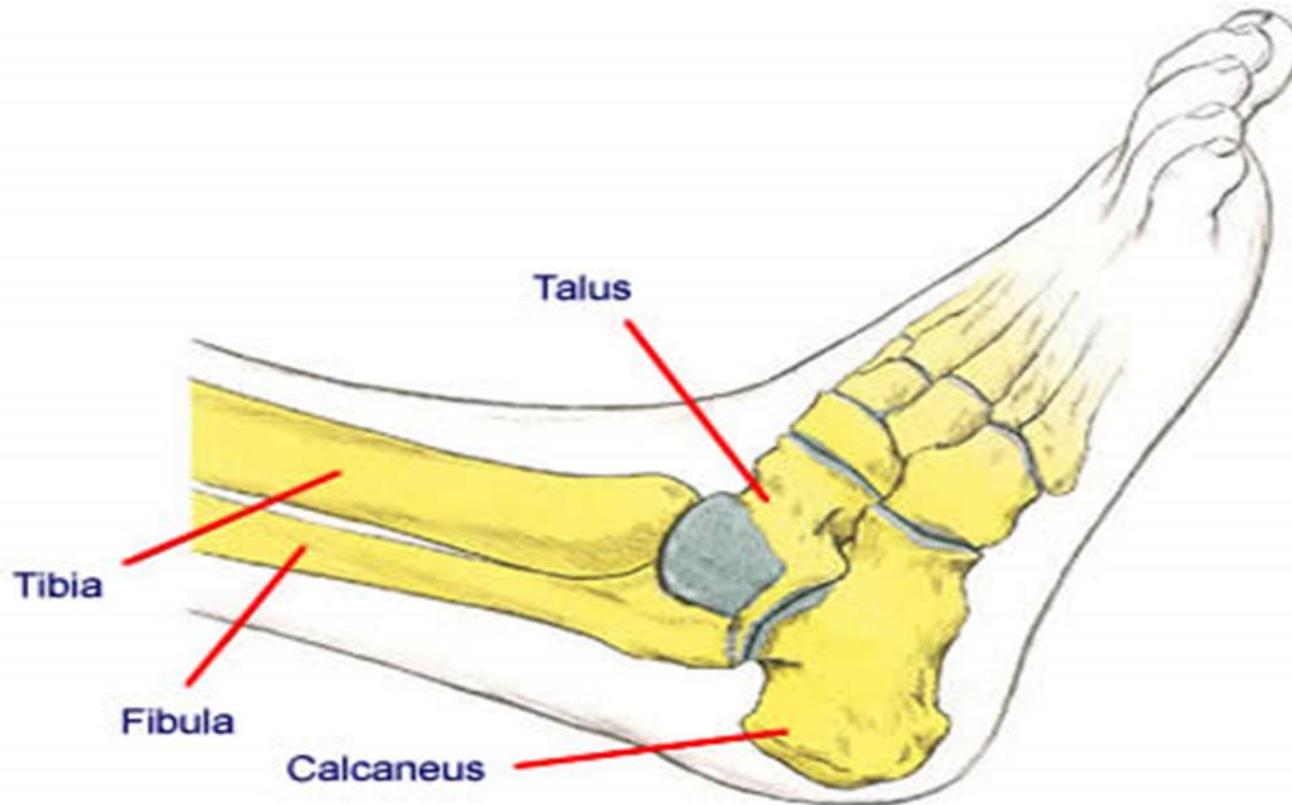
Interventions for Prevention

- Repositioning
 - Support surface
 - Tissue tolerance / Skin condition
 - Mobility / Activity level
 - Treatment goals / Comfort
- Positioning Devices
 - No “donuts”
 - Natural sheepskin – yes; synthetic - no
- Seated Individuals



• National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Heel Pressure Ulcers



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Heel Pressure Ulcers

- Pressure redistribution mattresses DO NOT prevent heel pressure ulcers
- Heel pressure ulcers CAN be prevented



Preventing Heel Pressure Ulcers

- Inspect heels every day, every shift
- Skin prep at bedtime to protect from friction
- If they cannot raise their leg off the bed, you need to protect the heels from pressure
- Float heels with pillow or wedge under the calves so that the heels float in the air
- Heel boots for those that cannot keep their legs on the pillow or wedge
- Avoid tight socks or shoes

Rehabilitation Therapists

- Promote mobility
- Recommend protective and positioning devices
- Assists with seating and positioning
- Ordering durable medical equipment to improve person's functional status



Rehabilitation Therapists

- National Pressure Ulcer Advisory Panel
 - Provide adequate seat tilt to prevent sliding forward in the wheelchair or chair, and adjust footrests and armrests to maintain proper posture and pressure redistribution.
(Strength of Evidence = C)
 - Avoid use of elevating leg rests if individual has inadequate hamstring length (if inadequate length and elevated leg rests used, pelvis is pulled into sacral sitting posture causing increased pressure on coccyx or sacrum) (Strength of Evidence = C)
 - “Consider the use of electrical stimulation for anatomical locations at risk of pressure ulcer development in spinal cord injury patients.” (Strength of Evidence = C)
 - National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Dietitian

- Performs nutritional assessments
- Develops nutritional plan of care
- Monitors and evaluates nutritional goals



Dietitian

- American Medical Directors Association
 - Research supports an association between malnutrition and pressure ulcer development
 - Evidence is weak that specific nutritional interventions beyond meeting basic calorie and protein requirements will prevent ulcers



Dietitian

- National Pressure Ulcer Advisory Panel
 - Follow EB guidelines on nutrition and hydration for individuals at nutritional risk, **at risk of pressure ulcers**, or have an existing pressure ulcer (Strength of Evidence = C)
 - Although a large amount of research has occurred in the area of nutrition and pressure ulcers, most of the existing evidence base is inconsistent and of low quality due to small sample size and either an unclear or high risk of bias
 - Posthauer ME, et al. The role of nutrition for pressure ulcer management: National pressure ulcer advisory panel, European pressure ulcer advisory panel, and pan pacific pressure injury alliance white paper. *Advances in Skin & Wound Care* 2015;28(4):175-188.

Dietitian

- National Pressure Ulcer Advisory Panel
 - Revise, modify, liberalize dietary restrictions when limitations result in decreased food and fluid intake (Strength of Evidence = C)
 - Offer high calorie, high protein nutritional supplements in addition to usual diet to those **at pressure ulcer risk**, if nutritional requirements cannot be met by dietary intake (Strength of Evidence = A)
 - Encourage an individual **at risk of a pressure ulcer** to take vitamin and mineral supplements when diet intake is poor or deficiencies are confirmed or suspected (Strength of Evidence = C)
 - Posthauer ME, et al. The role of nutrition for pressure ulcer management: National pressure ulcer advisory panel, European pressure ulcer advisory panel, and pan pacific pressure injury alliance white paper. *Advances in Skin & Wound Care* 2015;28(4):175-188.

Pharmacist

- Analyzes medication profile
- Alert clinical staff to possible interactions that might adversely affect the patient
- Medication availability
- Formulary alternatives



Pharmacist

- Collaborates with medical team
- Assist with modifying or stabilization of risk factors
 - Pain control
 - Edema
 - Spasticity
 - Incontinence
- Vitamin and mineral supplements

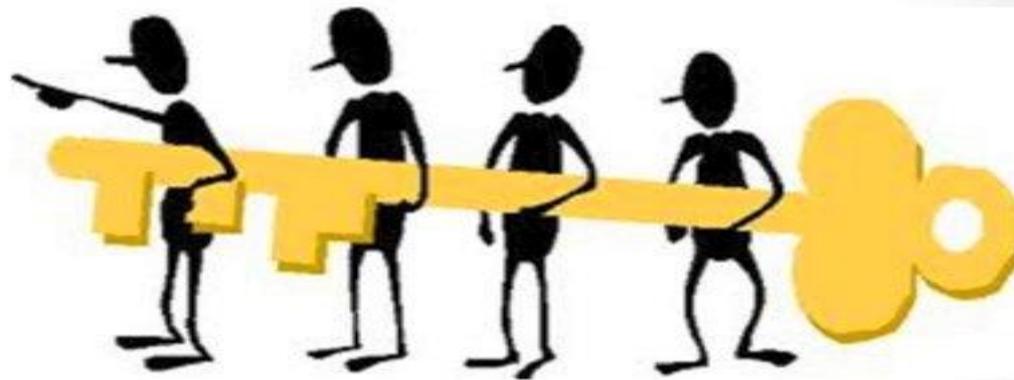
"We combined all your medications
into ONE convenient dose."



NICKEL

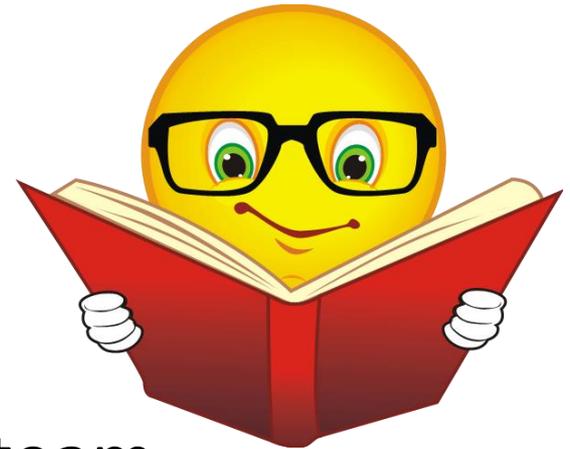
System Level Roles

- Education
- Informatics
- Quality Management
- Materials Management



Education

- Etiology and risk factors
- Risk assessment; skin assessment
- Staging; differential diagnosis
- Documentation
- Nutrition
- Use of equipment
- Importance of interdisciplinary team
- Patient and caregiver education



• National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Informatics

- Accurate and effective communication
- Assist with set up of systems to promote communication among the team
- Prevention intervention template



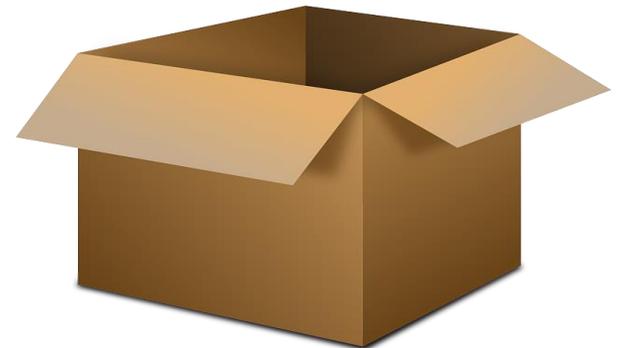
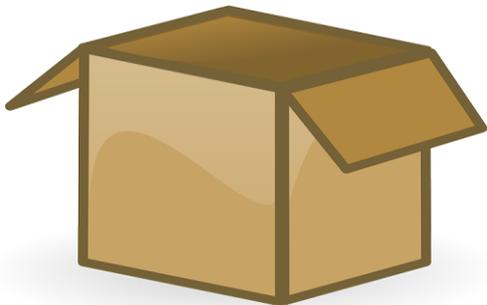
Quality Management

- Monitor and evaluate pressure ulcer rates
- Data analysis
- Identify patterns and trends
- Initiate performance improvement projects



Materials Management

- Promotes safe quality cost effective products
- Provides availability of products and devices
- Prevent Medical Device Related (MDR) ulcers
- Prevent Medical Adhesive Related Skin Injury (MARSI)



Medical Device Related Pressure Ulcers

- Tracheostomy securement devices, CPAP mask, oximeter probes, O2 tubing/nasal cannulas
- Cervical collars, helmets, external fixators, immobilizers (splints/braces), plaster casts
- Foley catheters, fecal containment devices
- Surgical drains, CVC, dialysis catheters
- Graduated compression stockings
- Restraints
- www.npuap.org Resources>Educational and Clinical Resources> ***Best Practice for Prevention of Medical Device Related Pressure Ulcers in Long Term Care***

Assessment and Prevention of Medical Device Related Pressure Ulcers

- Inspect skin under & around device 2x daily
- Keep skin clean & dry under devices
- Do not position directly on device if possible
- Rotate or reposition devices when possible
- Consider using a prophylactic dressing
- MDR pressure ulcers are staged using NPUAP Classification System - except for mucosal pressure ulcers

- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Emerging Therapies for Prevention of Pressure Ulcers

- Microclimate control
- Fabrics and textiles
- Prophylactic dressings



Prophylactic Dressings

- Bony prominences subjected to friction/shear
- Manage skin microclimate
- Ease of application & removal
- Ability to regularly assess skin
- Correct size
- Continue all other preventive measures
- Assess skin daily

• National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.

Systems Analysis

- How can an interdisciplinary team impact a system issue such as high pressure ulcer rates?



Systems Analysis

- Analyze each team members role in prevention
- Evaluate where a breakdown in the process occurred
 - Most barriers to quality care occur with processes, not individual people
 - Communication – protocol? referral?
 - Equipment, device, or product – available? effective?
- Corrective action plan to prevent further occurrence
 - Improvement will not occur without a change in process, system, or behavior

A New Paradigm

- **Pressure Ulcer Prevention is Everyone's Job!**



References

- American Medical Directors Association. Pressure Ulcers in the Long-Term Care Setting Clinical Practice Guideline. Columbia, MD: AMDA 2008
- Centers for Medicare and Medicaid Services. State Operations Manual, Guidance to Surveyors for Long Term Care Facilities,(Rev. 70, 01-07-11).
- Fowler, E., Scott-Williams, S., & McGuire, J., (2008). Practice recommendations for preventing heel pressure ulcers, *Ostomy and Wound Management*, 54(10).
- How will we manage change?: Preventing pressure ulcers in hospitals: A toolkit for improving quality of care. April 2011. Agency for Healthcare Research and Quality, Rockville, MD
- Moore Z, et al. AAWC, AWMA, EWMA Position Paper: Managing wounds as a team. *Journal of Wound Care* 2014; 23(5 Suppl.):S1-S38.
- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and treatment of pressure ulcers: Clinical practice guideline. Emily Haesler (Ed.). Cambridge Media: Perth, Australia; 2014.
- National Pressure Ulcer Advisory Panel. The Role of Nutrition in Pressure Ulcer Prevention and Treatment: National Pressure Ulcer Advisory Panel White Paper, 2009
- Wound Ostomy and Continence Nurses Society. Guideline for prevention and management of pressure ulcers. New Jersey: WOCN; 2010.

ARE **YOU** READY FOR THE **CMS MDS & STAFFING** **SURVEY PROCESS**

BY:

KIMBERLY SMOAK, MSH, QIDP
CHIEF OF FIELD OPERATIONS

AGENCY FOR HEALTH CARE ADMINISTRATION

ROBIN A. BLEIER, RN, LHRM, CLC
PRESIDENT RB HEALTH PARTNERS, INC.

Coming to you or your colleague soon!

Today's Program Objectives

Today's Program Objectives

1. Explain what the CMS MDS Survey Process is?
2. Discuss the Pilot Project, and Florida surveys and results.
3. Affirm the Entrance Conference process.

Objectives (continued)

4. List the Data and the Four Time Frames for submission you would be expected to follow.
5. Discuss Staffing aspects for Compliance.
6. List Steps for YOUR success.

Let's Get Started!

CMS MDS Survey Process

Dear Administrator

This letter is to inform the facility that they will be included in a MDS focused survey which per the Survey & Certification Memo 15-06 NH October 2015 is a nationwide initiative. The letter references that two to four surveyors will plan to be on site for two days (not in advance).

It is **not** with advance notice.

Entrance Conference

Using the Facility Copy of the Entrance Conference, providers will note that there are four categories each with associated time frames to provide specified data to the surveyors completing your compliance review.

Entrance Conference

The **Time Frames** are:

- ❖ Immediately Upon Entrance
- ❖ Within One Hour of Entrance
- ❖ Within 24 Hours of Entrance
- ❖ Upon Request or as needed

Immediately Upon Entrance

There are **six pieces** for this section:

1. Worksheet # 1 Resident Census Sheet
(alphabetical with room numbers)
2. Computer access
3. Facility Floor Plans

Immediately Upon Entrance

4. Transfer Records for the last 90 days
5. Identification of Wound Care Nurse (or nurse who coordinates wound care)
6. Identification for who is responsible for staffing

Within One Hour of Entrance

There are **four pieces** for this section:

7. Key personnel list with location and ext.
8. Computer access
9. All facility policies and procedures related to resident assessment instrument (RAI), including the minimum data set (MDS)
10. All facility policies and procedures related to staffing and scheduling

Within 24 Hours of Entrance

There is **one piece** for this section:

11. Completed CMS form 671 (Medicare Medicaid application)

Pilot Test

In the initial pilot testing, there were five states that participated.

The testing ended August 2014 and included a total of 25 SNFs.

Pilot Test Activities

These facilities were surveyed for:

- MDS coding accuracy,
- accurate MDS-based reimbursement levels, and
- RAI focused care planning that matches resident needs and promotes person-centered care.

Pilot Test Results

The results were not complimentary, of the 25 facilities surveyed, 24 received deficiencies for errors related to MDS coding.

CMS cited several prominent areas.

Pilot Test Results

CMS Cited Areas:

- Errors in MDS coding (esp. in certain sections)
- Inaccurate staging and documentation of pressure ulcers
- Lack of knowledge regarding classification of antipsychotic medication
- Poor coding regarding the use of restraints

To Have Upon Request

12. Make staff members and other policies and procedures available to surveyors upon request.

Avoid Possibly Citations

P

Did YOU P.R.E.P.A.R.E.?

R

P-prepare in advance

E

R-review the findings of others

P

E-encourage daily compliance

A

P-plan to audit routinely

R

A-assure your plan is in place

E

R-read the public findings

E-enjoy the fruits of your labor

History Helps Us Prepare

Reviewing the results of others helps us to prepare for the future. Results from the states that were included in the initial survey findings support our learning and guide additional review; however, the **real key** is to use and embrace the directions in the MDS manual especially the item-by-item section.

Citations

If non-compliance is identified during this process, based on the experiences of the 25 facilities already surveyed, your facility may expect citation in one or more of the following (but not limited to):

- ✓ F 157 Notification of Change
- ✓ F 272 Not Assessing Timely
- ✓ F 273 Not Assessing Timely

Citations

- ✓ F 274 Significant Change in Condition
- ✓ F 275 Not conducting annual assessment timely
- ✓ F 276 Not conducting quarterly assessment timely

Citations

- ✓ F 278 Inaccurate coding (skin, antipsychotic medications, accurately reflect status)
- ✓ F 280 Failure to include resident in care plan
- ✓ F 281 Scope/practice LPN (prof. standards)

Citations

- ✓ F 282 Qualified individuals
- ✓ F 287 Encoding/Transmitting data timely
- ✓ F 323 Failure to provide equipment to assist with fall prevention

Citations

- ✓ F 315 Timely evaluation for catheter removal
- ✓ F 329 Failure to monitor for psychotropic medication effectiveness
- ✓ F 520 Failure to monitor MDS assessment accuracy and failure to develop action plan to correct identified non-compliance

Staffing Compliance

Nursing Staffing Information

Federal nurse daily staffing information posting requirement includes:

- ✓ Facility Name
- ✓ Current Date
- ✓ Total number and actual hours worked by the following categories:
 - registered nurses
 - licensed practical nurses
 - certified nurse aides

and

Nursing Staffing Information

Federal requirements continued:

- ✓ Resident census
- ✓ Post at the beginning of each shift
- ✓ Post must be:
 - clear and readable format
 - in a prominent location easily accessible to residents and visitors

and

Nursing Staffing Information

Federal requirements continued:

- ✓ Provide public access, (upon oral or written request), make nursing staffing data available to the public for review at a cost not to exceed the community standard.
- ✓ Facility data retention requirements, maintain posted daily nurse staffing data for a minimum of **18 months**, or as required by State law, whichever is greater.

Preparation is Key!

It is not too late to prepare for success! While the first 11 Florida surveys were completed by September 30th (FYE), CMS requires that they be continued.

Key to Preparation...

Successful facilities embrace the RAI manual and the MDS coding directions in the manual Chapter 3.

Ready or Not Here CMS Comes!

YOUR STEPS FOR SUCCESS!

A few questions to consider:

1. Evaluate your facility risk.
2. Affirm you have the listed policies and procedures?

Ready or Not Here CMS Comes!

3. Audit to affirm to assure that your MDSs are coded to match your residents during the assessment reference date (ARD)?
4. Audit to affirm if your assessments (CAAs) & Care Plans reflect resident centered & directed care?

In Conclusion

The CMS MDS & Staffing Survey is here to stay. A few questions:

- How are **YOU** the licensed Nursing Home Administrator inspecting what you expect?
- Do you have the Policies and Procedures required?
- What is your system to assure:
 - Care plan compliance
 - Posting Compliance

Finally...

At the end of the Day...F 490 is about how the licensed nursing home administrator manages to ensure compliance of these and all requirements regardless if you personally know how to or have time to complete the designated tasks or not.

We Thank You!

Thank you for attending our session.

To reach Kimberly Smoak please:

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Call: 850.412-4516 or 850.559.8273

To reach Robin please:

Email: robin@rbhealthpartners.com

Call: 727.786.3032

Florida FY 2015 CMS MDS & Staffing Focused Surveys

Facility City		Tag And Severity/Scope	DPOC
1.	Jacksonville	F356 (F)	Yes (F356)
2.	Venice	F278 (D), F280(D) and F356(F)	Yes (F356)
3.	Ft. Meyers	F278 (D), F280 (D), F282 (D), F314 (D), F315 (D), F329 (D), F356 (F)	Yes (F356)
4.	Port St. Lucie	F278 (E) and F329 (D)	No
5.	Winter Haven	F278 (D), F356 (F), F514 (D)	Yes (F356)
6.	Lakeland	F278 (D), F280 (D), F314 (D), F315 (D), F329 (D), F356 (F), F514 (D)	Yes (F356)
7.	Leesburg	No Deficiencies	
8.	St. Petersburg	F174 (E), F314 (D), F323 (G), F356 (E), F441 (D)	Yes (F356)
9.	Sun City Center	F278 (D), F329 (D), F356 (F)	Yes (F356)
10.	Gainesville	F278 (E) and F356 (F)	Yes (F356)
11.	Lakeland	F278 (E) and F279 (D)	No
12.	St. Petersburg	F278 (D)	No
13.	Clearwater	F278 (D) and F356 (F)	Yes (F356)
14.	Palm Harbor	F278 (D), F356 (F)	Yes (F356)
15.	Crawfordville	F174 (D), F278 (E), and F356 (F)	Yes (F356)
16.	Port Charlotte	F278 (E), and F356 (F)	Yes (F356)

Most commonly cited tags: F278 (13 facilities) and F356 (12 facilities)

FADONA
CARRYING THE TORCH OF LEADERSHIP
2016

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Disclaimer



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Objectives

- **Objectives: At the end of this program participants will be able to:**
- Identify heel anatomy & physiology related to pressure ulcer development
- List the primary risk and causative factors for the development of heel pressure ulcers
- Discuss current recommendations from national & international guidelines for prevention and treatment of heel pressure ulcers.

Notations in Top Left Corners

NPUAP

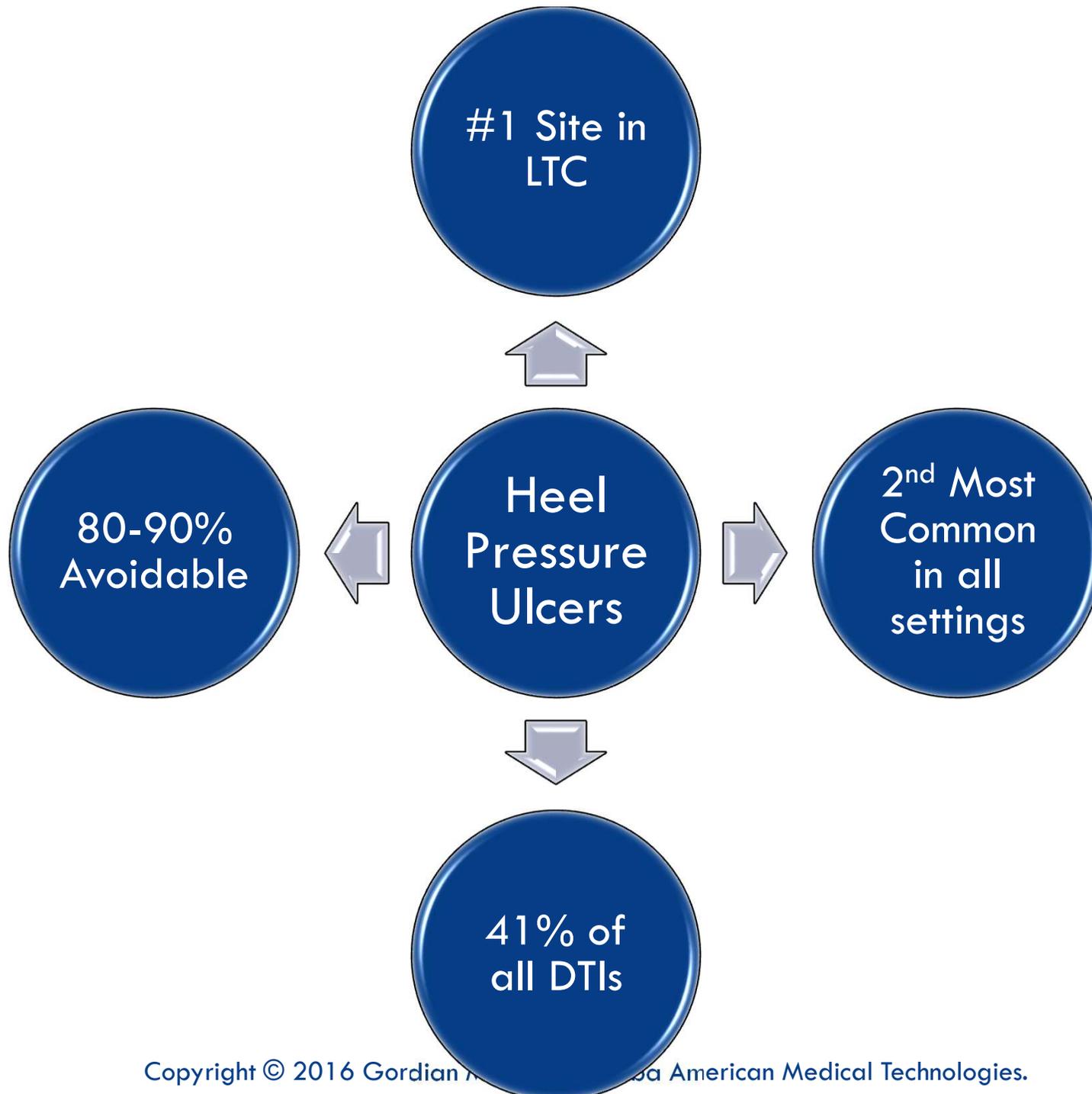
**National Pressure Ulcer Advisory Panel,
European Pressure Ulcer Advisory Panel, Pan
Pacific Pressure Injury Alliance, Prevention and
Treatment of Pressure Ulcers: Clinical Practice
Guideline.**

MDS 3.0

**CMS Resident Assessment Instrument;
Minimum Data Set-3.0, M-Section**

**CMS
SOM**

**Centers for Medicare and Medicaid Services
State Operations Manual
Guidance to Surveyors**



Pressure Ulcers

- >2.5 million people in US develop pressure ulcers
- Estimated cost of care in US: 9.1-\$11.6 billion
- Range of cost for treating \$2000-\$21,000 per ulcer
- Most severe pressure ulcer (Stage IV) at sacrum (~40%,) & heels (~39%)



Pressure Ulcers

- Can lead to life-threatening complications; infections, gangrene, sepsis, death
- ~60,000 die as direct result of pressure ulcers
- Contributes to increased debilitation for patients/residents on top of causes of pressure injury (i.e. immobility)
- Increases health care utilization and costs
- Largely affect most vulnerable population, those over 75

Other Issues Related to Pressure Ulcers

- Litigation
 - > 17,000 PrU related suits filed annually
 - Second only to wrongful death lawsuits
 - Average settlement \$250,000
 - As high as \$312 million
- Government oversight and penalties
 - Office of Inspector General-related to resident safety & “harm”
 - Survey process (think F314)-CMS instructs surveyors to review QAA committee activities
- Impact of facility performance metrics-Quality Measures
- CMS gathers data on percentage of residents who develop pressure ulcer in facilities

Table 4: Temporary Harm Events Identified Among SNF Residents by Category

Types of Temporary Harm Events	Percentage*
<p>Events Related to Medication</p> <ul style="list-style-type: none"> • Hypoglycemic episodes (e.g., low or significant drop in blood glucose) 16% • Fall or other trauma with injury associated with medication 9% • Medication-induced delirium or other change in mental status 7% • Thrush and other nonsurgical infections related to medication 4% • Allergic reactions to medications (e.g., rash, itching) 3% • Other medication events 3% 	<p>43%</p>
<p>Events Related to Resident Care</p> <ul style="list-style-type: none"> • Pressure ulcers 19% • Fall or other trauma with injury associated with resident care 8% • Skin tear, abrasion, or breakdown 7% • Other resident care events 6% 	<p>40%</p>
<p>Events Related to Infections</p> <ul style="list-style-type: none"> • CAUTI 5% • SSI associated with wound care 5% • Other infection events 7% 	<p>17%</p>
<p>Total</p>	<p>100%</p>

Heel Pressure Ulcers

- Of all pressure ulcers, ~24-30% develop on the heel and 6.1% on the malleolus (ankle bone)
- Second and fifth most common sites on the body.



Risk Factor for Heel Pressure Ulcers

Extrinsic Factors

- Pressure
- Friction
- Shear

Intrinsic Factors

- Advanced age
- Immobility
- Neuropathy
- Nutrition/hydration issues
- PAD
- Lower extremity edema
- Comorbidities (i.e. DM)
- Contractures



Number 1 Reason for Acquiring Heel Pressure Ulcers

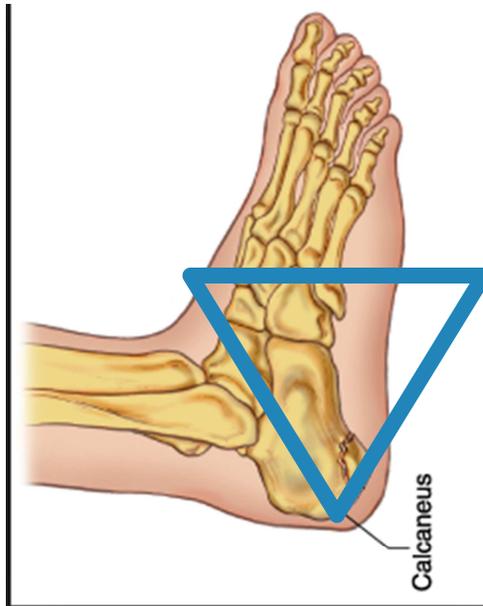
Immobility

Everything else is a
contributing factor

Anatomy and Physiology of the Heel

**What does anatomy
have to do with it?**

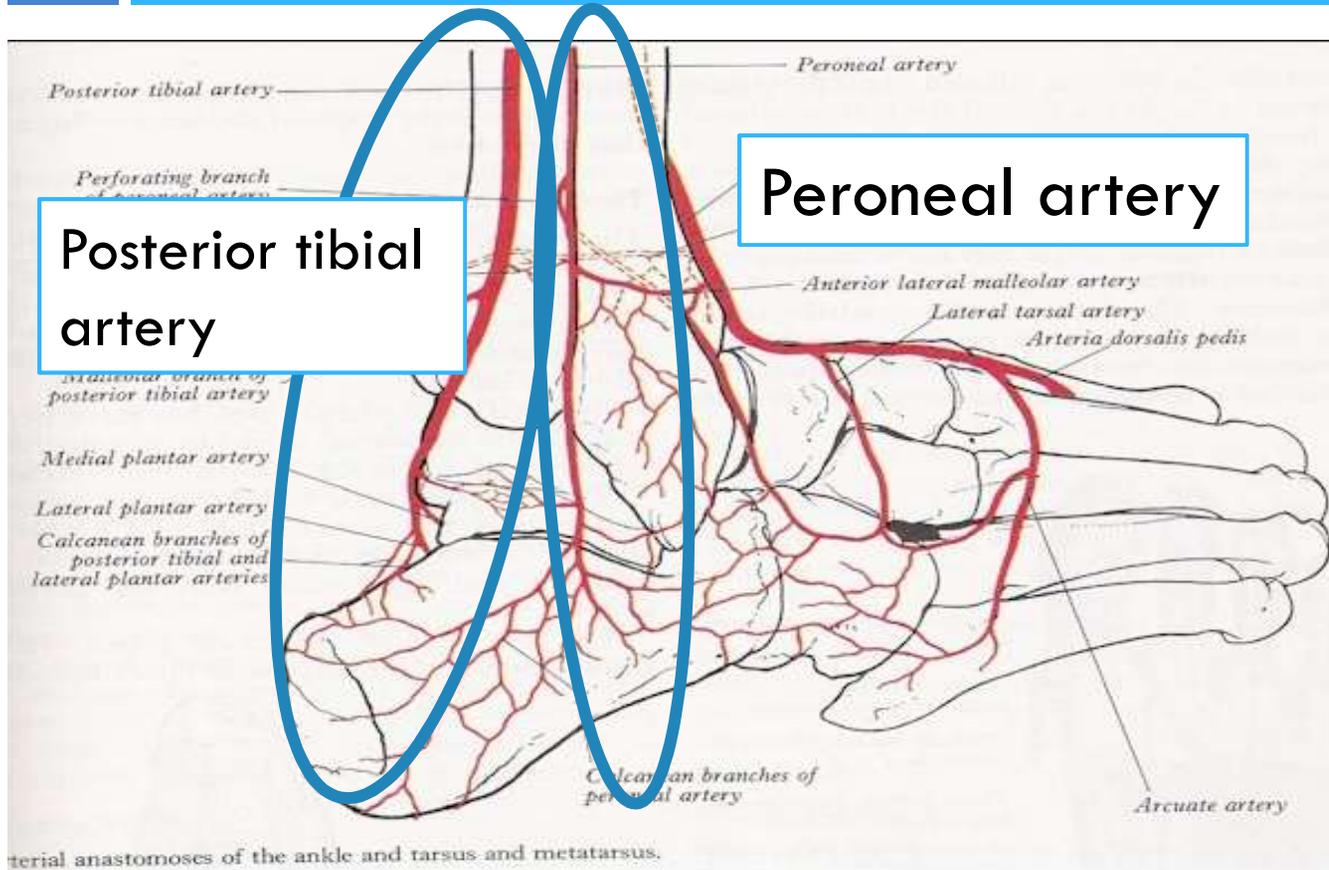
Anatomy of Heel



Pressure point
Small area

- ❑ Lower leg (with bone, muscle, tissues, fluids)
- ❑ Calf may or may not take part of the weight...depending on the muscle bulk in the calf muscles
- ❑ Severely atrophied muscles of calf will put more weight resting on posterior heel when person supine
- ❑ All this weight is focused on a very small area...the posterior aspect of the calcaneus bone

Blood Supply to Heel

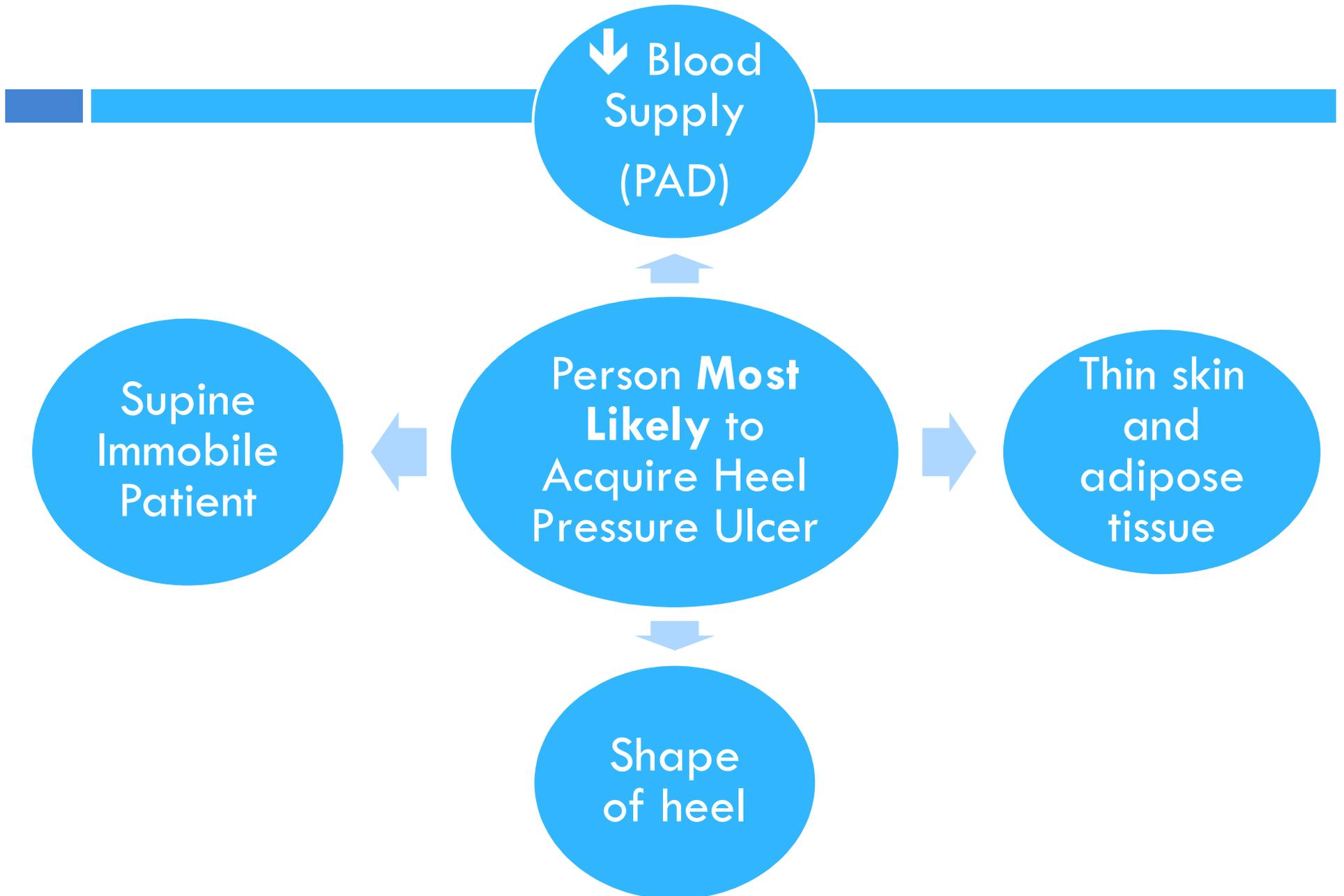


- Blood supply often compromised in older population due to PAD
- More so in people with DM
- Decreased blood flow, thinning skin and subcutaneous tissue makes heel more susceptible to pressure injury

Why is Blood Flow Important?

- Vascular experts suggest Stage 1 & 2 heel pressure ulcers *MAY* heal with moderate peripheral arterial disease⁴
- But...Stage 3 & 4 heel pressure ulcers will not heal without pulsatile flow to the foot⁴
- Vascular study most often used in out-patient setting is arterial Doppler studies
- Blood flow **EXTREMELY** important for both prevention and healing of heel pressure ulcers

The Perfect Storm



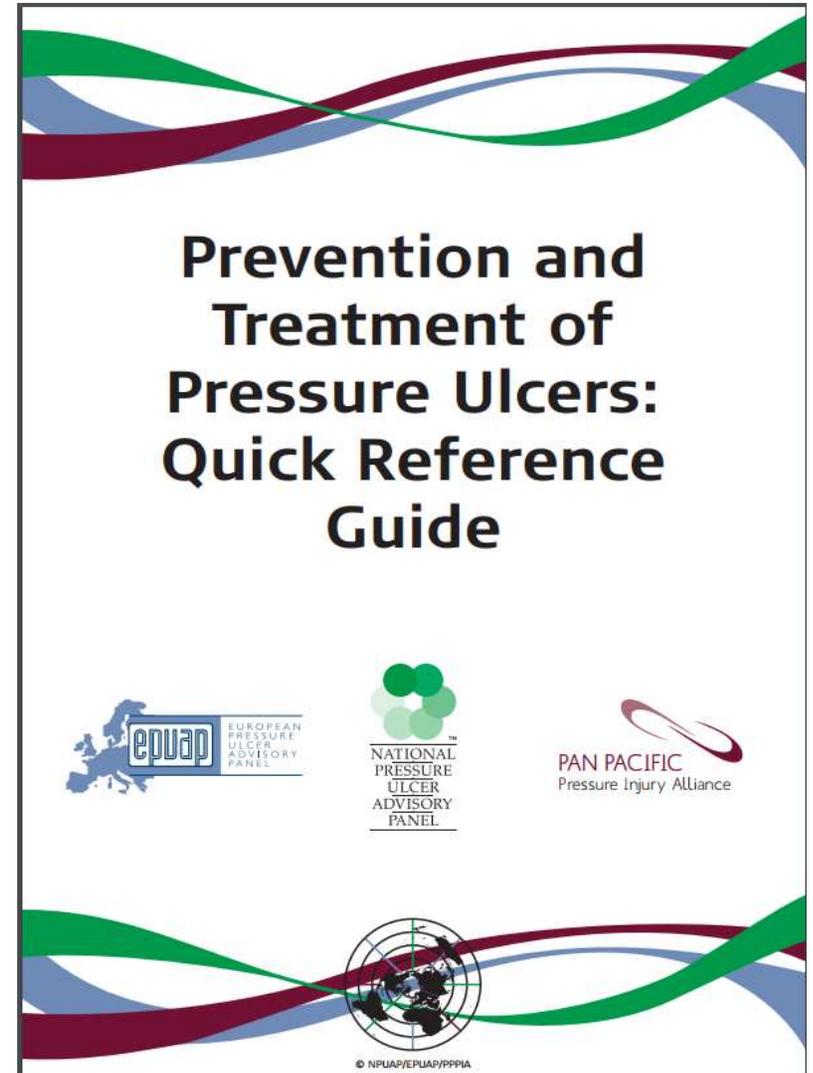
The Importance of the Team!!!

- Highest reduction of facility acquired PrU happened in facilities where there was:
 1. Resident participation
 2. Multidisciplinary team
 3. Integration of ALL clinical report



Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline

- National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel, Pan Pacific Pressure Injury Alliance, Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. Emily Haesler (Ed.). Cambridge Medial: Perth, Australia; 2014.¹
- NPUAP.org for complimentary Quick Reference Guide



Strength of Evidence Notations in Guideline

Strengths of Evidence

A	The recommendation is supported by direct scientific evidence from properly designed and implemented controlled trials on pressure ulcers in humans (or humans at risk for pressure ulcers), providing statistical results that consistently support the recommendation (Level 1 studies required).
B	The recommendation is supported by direct scientific evidence from properly designed and implemented clinical series on pressure ulcers in humans (or humans at risk for pressure ulcers) providing statistical results that consistently support the recommendation. (Level 2, 3, 4, 5 studies)
C	The recommendation is supported by indirect evidence (e.g., studies in healthy humans, humans with other types of chronic wounds, animal models) and/or expert opinion.

Strengths of Recommendations

	Strong positive recommendation: definitely do it
	Weak positive recommendation: probably do it
	No specific recommendation
	Weak negative recommendation: probably don't do it
	Strong negative recommendation: definitely don't do it



Conducting Skin and Tissue Assessment

- In individuals at risk of pressure ulcers, conduct a comprehensive skin assessment:
 - ▣ **as soon as possible but within a maximum of eight hours after admission as part of every risk assessment,**
 - ▣ **ongoing based on the clinical setting and the individual's degree of risk, and**
 - ▣ **prior to the individual's discharge.**
- **SoE=C; SoR=👍**

Conducting Skin and Tissue Assessment

- Increase the frequency of skin assessments in response to any deterioration in overall condition.
 - **SoE=C; SoR=👍**
- Conduct a head-to-toe assessment with particular focus on skin overlying bony prominences including the sacrum, ischial tuberosities, greater trochanters and heels.
- Each time the patient is repositioned is an opportunity to conduct a brief skin assessment.

Ongoing Skin Assessment Skin Considerations

- Remove devices on feet on regular basis
- At least daily
- More than once a day if high risk for skin breakdown
- Specifically
 - TED hose
 - Support stockings
 - Heel protectors or suspension devices



Inspect Skin for Erythema

- Inspect skin for erythema in individuals identified as being at risk of pressure ulceration.
 - ▣ **SoE=C; SoR=👍👍**
- ***Caution: Avoid positioning the individual on an area of erythema wherever possible.***



M0300B: Stage 2 Pressure Ulcers

- 3. Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.**
4. Stage 2 pressure ulcers will generally lack the surrounding characteristics found with a deep tissue injury.

Cause and Extent of Erythema

- Differentiate the cause and extent of erythema.
 - SoE=C; SoR=👍👍
- Differentiate whether the skin redness is **blanchable** or **nonblanchable**.



Stage I with non-blanchable erythema

Methods for Blanching

- **Use finger or disc method to assess whether skin is blanchable or non-blanchable.**
 - finger pressure method — finger is pressed on erythema for three seconds and blanching is assessed following removal of the finger;
 - transparent disk method — a transparent disk is used to apply pressure equally over an area of erythema & blanching can be observed underneath the disk during its application.



Blanch Every Heel

- Blanch every heel during skin assessment
- Non-blanchable-pressure injury present



F314-State Operations Manual

- Erythema or color changes on areas such as the sacrum, buttocks, trochanters, posterior thigh, popliteal area, or heels when moved off an area:
- If erythema or color change are noted, return approximately $\frac{1}{2}$ - $\frac{3}{4}$ hours later to determine if the changes or other Stage I characteristics persist

NPUAP

Inspect the Skin of the Heels Regularly (SoE=C; SoR=👍👍)



AHRQ-Recommends Use of Mirrors

Preventing Pressure Ulcers in Hospitals



A Toolkit for
Improving
Quality of Care

Pressure Ulcers. January 2015.
Agency for Healthcare Research
and Quality, Rockville, MD.

<http://www.ahrq.gov/professionals/systems/long-term-care/resources/pressure-ulcers/index.html>



AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov



Two Practical Tips for Preventing Heel Pressure Ulcers

Number 1

- Float heels

Number 2

- Use mirrors to check heels and other hard to see areas



Pressure Ulcer Prevention

Tip of the Month



Quality Improvement
Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES



Original materials developed by Mountain-Pacific Quality Health. This material was prepared by Healthcare Quality Strategies, Inc., the Medicare quality improvement organization for New Jersey, under contract with the CMS, an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy.

Why Mirrors?

- Provide reflective surface
- Helps staff visualize hard-to-see areas
- Provides method for examining skin in hard to see areas without having to maneuver immobile patients/residents



Preventing Pressure Ulcers in Hospitals: A Toolkit for Improving Quality of Care. Agency for Health Research and Quality



Repositioning for Preventing Heel Pressure Ulcers

- Ensure that the heels are free of the surface of the bed. (SoE=C; SoR=👍👍)
- Ideally, heels should be free of all pressure — referred to as “floating heels”

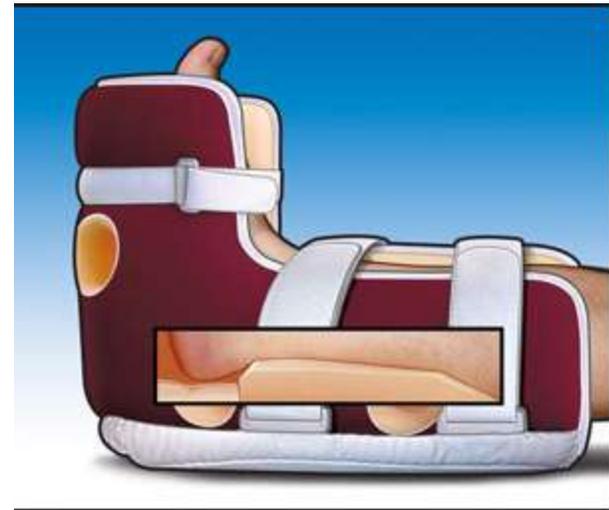


Heel Suspension Devices

- Use heel suspension devices that elevate and offload the heel completely in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon.
- SoE=B; SoR=👍👍



Pressure ulcer on Achilles tendon



Recommendations for Heel Suspension Devices

- Heel suspension devices are preferable for long term use, or for those individuals unlikely to keep their lower extremity on pillows
- Select devices based upon the individual's clinical condition, POC, patient/resident's tolerance of device, and **manufacturer's guidelines**



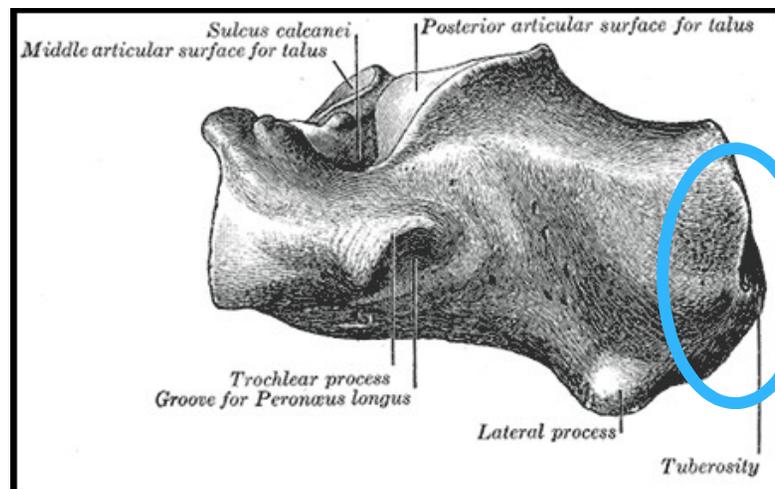
Recommendations for Heel Suspension Devices

- Some devices are not appropriate to be worn in bed due to risks of pressure injury on other parts of the leg (i.e. devices with metal support bars)
- Special care and observation for patient's/resident's with **contractures** or **decreased sensation (think diabetic neuropathy)** or **inability to communicate pain/discomfort** from pressure

NPUAP

Note: Pressure Redistribution Device A NOT Adequate¹

- Posterior prominence of heel (calcaneus with calcaneal tuberosity) sustain intense pressure, **even with a pressure redistribution mattress in use** (NPUAP, EPUAP, Pan Pacific Injury Alliance)
- Recommendation: use a heel suspension device even when using a pressure redistribution mattress



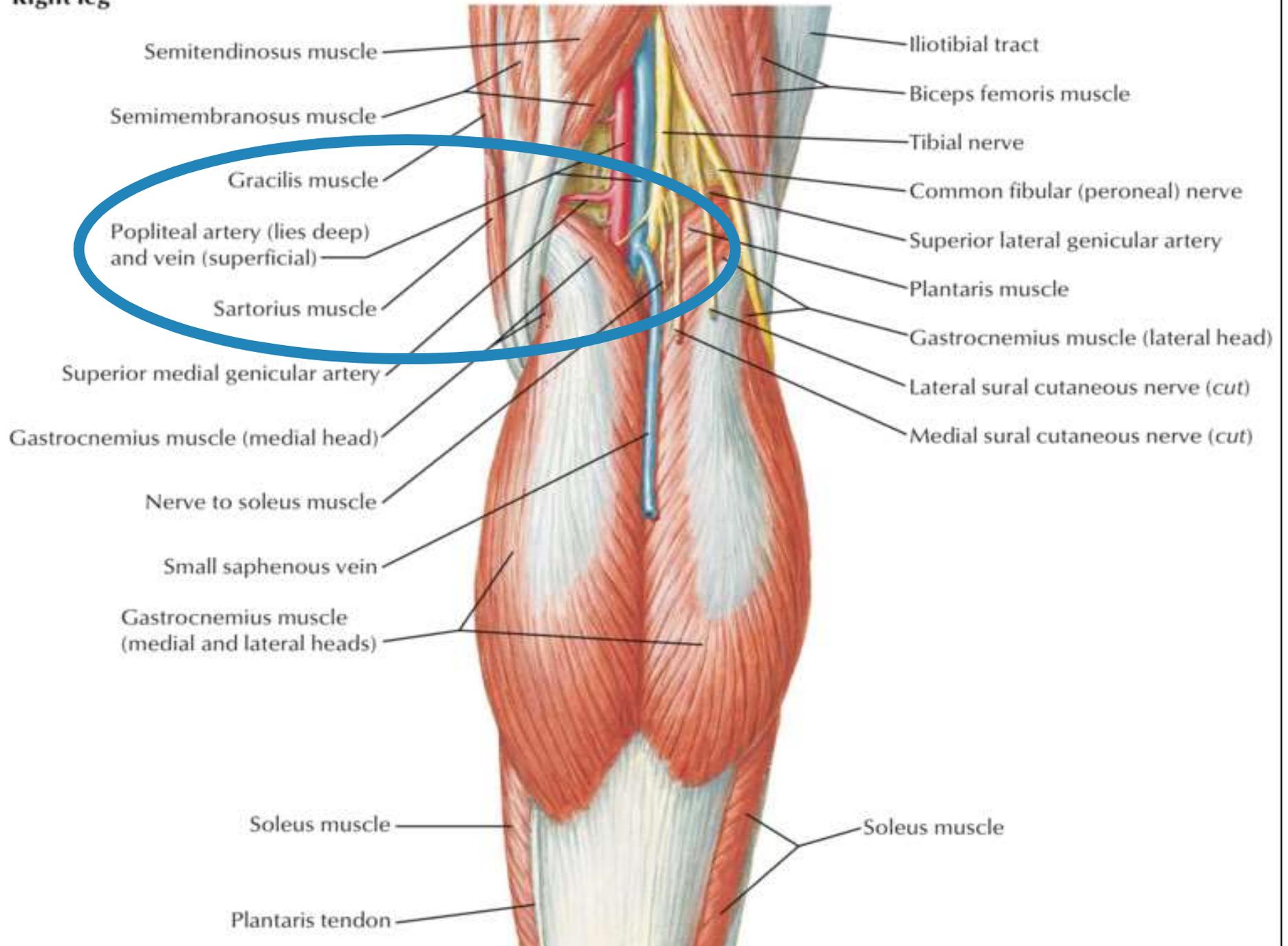


2014 NPUAP Guidelines for Heels

- Knee should be in slight (5° to 10°) flexion

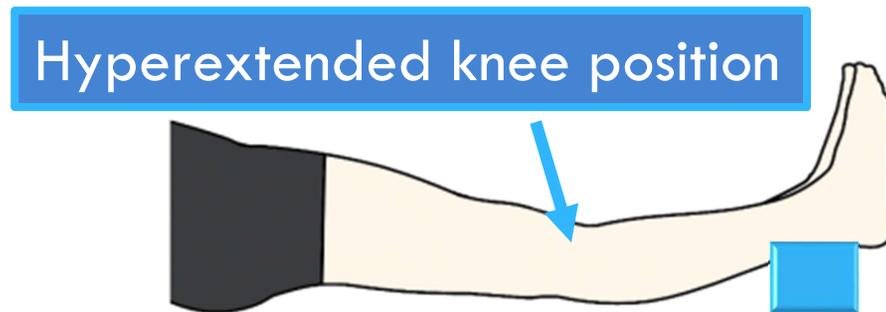
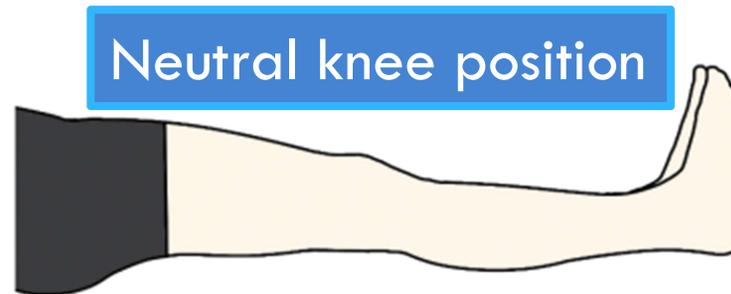


Right leg



Why Flex Knee?

- Indirect evidence that hyperextension of knee may cause obstruction of popliteal vein, which could predispose an individual to DVT.



Heel Protectors



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Study JWOCN

Heel protection device + heel ulcer prevention protocol:

Decreased heel PrUs 95%

Study JWOCN

Heel protector device:

100% prevention of both heel PrUs & plantar flexion contractures over 7-month period

Study – Poster 19th Annual CAWC Conference-2013

Heel PrU prevention protocol + heel protector device:

28% decrease in FA PrU over one-year.

Continued use of heel protector device over 4-years + in-depth education, continuous monitoring of compliance, and continual reporting of outcomes

72% decrease in heel pressure ulcers

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Protect the Achilles Tendon

- Avoid areas of high pressure, especially under the Achilles tendon (SoE=C; SoR=👍)
- Use a foam cushion under the full length of the calves to elevate heels (SoE=B; SoR=👍)
- Pillows or foam cushions used for heel elevation should extend the length of the calf to avoid areas of high pressure, particularly under the Achilles tendon.





Assess More Frequently

- Perform skin assessment and heel checks more frequently and loosen device in patients/residents:
- With or at risk for developing lower extremity edema (think CHF)
- Individuals with neuropathy – skin more susceptible to breakdown
- Individuals with peripheral arterial disease-skin more susceptible to breakdown

What to Look for in a Heel Protector Device

- ❑ Separate and protect ankles
- ❑ Maintain heel suspension “floating heels”
- ❑ Prevent foot drop or planter flexion contractions
- ❑ Exterior slides over bed sheets for freedom of movement
- ❑ Pressure distribution for calf within device
- ❑ Works for left or right leg/foot
- ❑ Holds foot in neutral position without external rotation (foot turning out putting pressure on lateral ankle)





Following Devices Should NOT be Used to Elevate Heels¹

- ❑ Do not use ring or donut-shaped devices for position.
(SoE= C; SoR= 👍👍)
- ❑ The following should not be used to elevate heels:
 - ❑ Synthetic sheepskin pads;
 - ❑ **Cutout, ring, or donut-type devices**
 - ❑ **Intravenous fluid bags**
 - ❑ **Water-filled gloves**
- ❑ All these products have been shown to have limitations.
 - ❑ (SoE=C; SoR=👍)
- ❑ **Natural** sheepskin pads might assist in preventing pressure ulcers.



Pillows as a Heel Protection Device

- Appropriate for short-term use
- Patient/resident must be able to keep foot on pillow with heel floated
- Place under full length of calves in alert/cooperative individuals
- Still need to flex knees 5-10° when using pillows



F 314 from State Operations Manual

- Because the heels and elbows have relatively little surface area, it is difficult to redistribute pressure on these two surfaces.
- Therefore, it is important to pay particular attention to reducing the pressure on these areas for the resident at risk in accord with resident's overall goals and condition.
- Pillows used to support the entire lower leg may effectively raise the heel from contact with the bed, but use of the pillows needs to take into account the resident's other conditions.
- The use of donut-type cushions is not recommended by the clinicians.



Repositioning Existing Heel Pressure Ulcers-Stage I or II

- Relieve pressure under the heel(s) with Stage I or II pressure ulcers by placing legs on a pillow to **'float the heels'** off the bed or by using heel suspension devices. (SoE = B; SoR = 👍)



Repositioning Existing Heel Pressure Ulcers – Stage III or IV

- For Category/Stage III, IV and unstageable pressure ulcers, place the leg in a device that elevates the **heel from the surface of the bed, completely offloading the pressure ulcer. Consider a device that also prevents footdrop.**
 - (SoE = C; SoR = 👍👍)



NOTE: *Elevation of the heel on a pillow is usually inadequate for Stage III & IV pressure ulcers*

Treatment of Existing Heel Pressure Ulcer

- Follow general guidelines for wound care; include by not limited to:
 - Offloading wound; frequent repositioning
 - Moist wound healing practices
 - ▣ Debridement of necrotic tissue
 - ▣ Preventing infections/treating chronic inflammation
 - ▣ Keeping the wound be moist (dressing selections, or compression (venous insufficiency, lymphedema)
 - ▣ Ensure wound edges able to migrate
- Address nutrition/hydration
- Mitigate comorbidities if possible (i.e. Diabetes-blood glucose control)

Eschar-Tread Carefully

- Do not debride stable, dry eschar in **ischemic** limbs
- (SoE=C; SoR=👍)
- Think stable heel eschar
- Assessment of ulcer covered with dry, stable eschar should be **performed at each dressing** change & as clinically indicated to detect the first signs of developing infection
- Stable dry eschar is usually not moistened



Coding Tips from MDS 3.0, M-Section

- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including **ruling out ischemia**, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

Best Practices for Pressure Ulcer Prevention

- Realize that implementing best practices at the bedside is an extremely complex task.
- Some of the factors that make pressure ulcer prevention so difficult include:
 - ▣ It is **multidisciplinary**: Nurses, physicians, dietitians, physical therapists, and patients and families are among those who need to be invested.
 - ▣ It is **multidimensional**: Many different discrete areas must be mastered.

Best Practices for Pressure Ulcer Prevention

- ▣ It needs to be **customized**: Each patient is different, so care must address their unique needs.
- ▣ It is also highly **routinized**: The same tasks need to be performed over and over, often many times in a single day without failure.
- ▣ It is not perceived to be **glamorous**: The skin as an organ, and patient need for assessment and care, does not enjoy the high status and importance of other clinical areas.

Summary for Prevention of Heel Pressure Ulcers

- Keys to improving pressure ulcer prevention:
 - Simplification and standardization of pressure-ulcer-specific interventions and documentation
 - Involvement of multidisciplinary teams and leadership
 - Designated skin champions
 - Ongoing in-depth education specific to heel and other site PrU prevention
 - Use **recognized clinical practice guidelines** to structure prevention program such as NPUAP, EPUAP, Pan Pacific Alliance, Wound Ostomy Contenance Nurses Society (WOCN)
- Sustained audit and feedback for promoting both accountability and recognizing successes

Prevalence and Incidence

- Point Prevalence
 - ▣ Number of patient with pressure ulcer at a specific point in time
 - ▣ Usually on a specific day
 - ▣ PrU may have developed recently, or over an extended period of time or may have been present on admission
- Cumulative Incidence
 - ▣ Number of patients developing new pressure ulcers during a specific time period
 - ▣ Weeks or months
 - ▣ Population free of pressure ulcers identified then followed for a specific time period, with periodic determinations of presence of pressure ulcers for each individual

Prevalence and Incidence Studies

- By assessing prevalence and incidence and subsequently creating process improvement programs to address skin care assessment and documentation, staff education, and pressure ulcer prevention interventions, facilities can and have achieved noteworthy success in preventing pressure ulcers, including heel pressure ulcers.
- www.o-wm.com/content/results-2008-%E2%80%93-2009-international-pressure-ulcer-prevalence%E2%84%A2-survey-and-a-3-year-acute-care-#sthash.TCEgpGqm.dpuf

Where We're Going

- Consider aging population
 - Percent of patients at risk for developing pressure ulcers is growing
 - Increased demand for early prevention and appropriate wound care strategies
- Does your facility have a plan in place for a pressure ulcer prevention and care program that meets today's standards and guidelines???

QUESTIONS?



AMT Education Division

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THANK
YOU!!!!

American Medical Technologies-Education Division

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How to Effectively Implement your Skilled Managed Care Plan Contracts

Learning Objectives (FADONA)

- Recognize the recent changes and current state of Managed Care Health Plans available for Skilled Nursing Homes.
- Distinguish the key financial differences between Medicare Advantage Plan contracts and Traditional Medicare Part A, how to effectively manage/optimize the contracts for maximum reimbursement and how nursing plays a major role.
- Recognize Key Documentation Areas for Skilled Managed Care Contracts as related to Nursing **and Therapy**.

Current State of Managed Care

- Medicare Advantage Plans
 - New flavors are being released
 - EPO
 - Delegated Plans
 - ACOs
- Exclusive Provider Organizations (EPO)

Current State of Managed Care

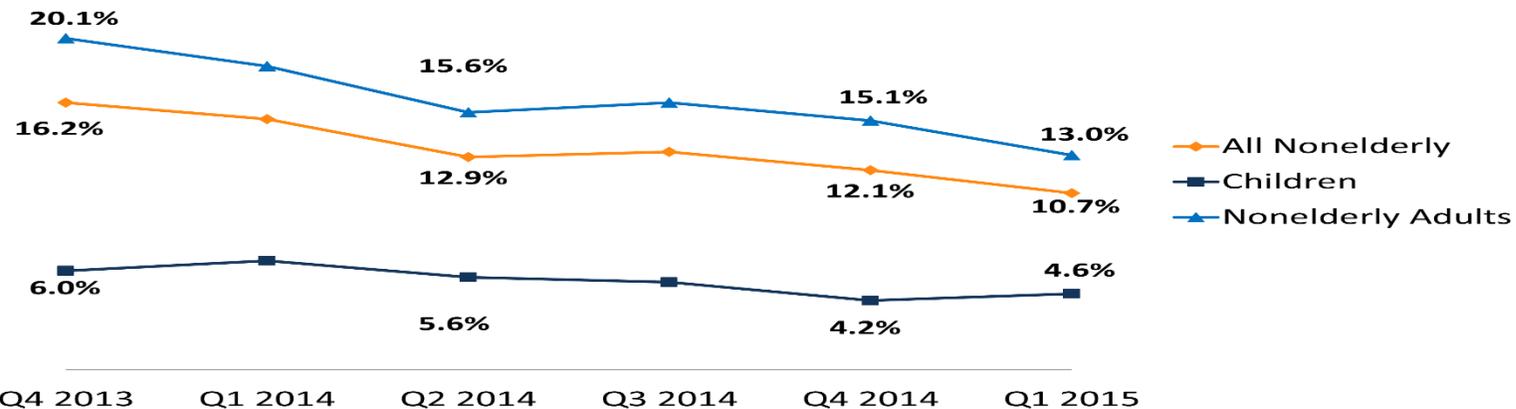
- Managed Medicaid
 - HMOs
 - Increase in Managed Medicaid being seen in the SNF
- Commercial Insurance
 - Exchange Products

The Insured Trends

- In 2013 there were 41 million uninsured in the U.S.A. or 16.2%
- In 2014 there were 32 million uninsured or 12.1%
- First Quarter of 2015 data indicated an uninsured rate of 10.7%

Figure 2

Quarterly Uninsured Rate for the Nonelderly Population by Age, Q4 2013-Q1 2015



SOURCE: National Center for Health Statistics. *Health Insurance Coverage: Early Release of Quarterly Estimates From the National Health Interview Survey, January 2010-March 2015*, August 12, 2015. Available at: http://www.cdc.gov/nchs/data/nhis/earlyrelease/Quarterly_estimates_2010_2015_Q11.pdf.



The Insured Trends (cont'd)

- **Employer Sponsored Plans**

- 52% of covered workers in 2015 were enrolled in a PPO plan
- 24% of covered workers in 2015 were enrolled in a HDHP/SO
 - High Deductible Health Plans with Savings Option
- 14% of covered workers in 2015 were enrolled in a HMO plan
- 10% of covered workers in 2015 were enrolled in a POS plan

- **Retiree Coverage**

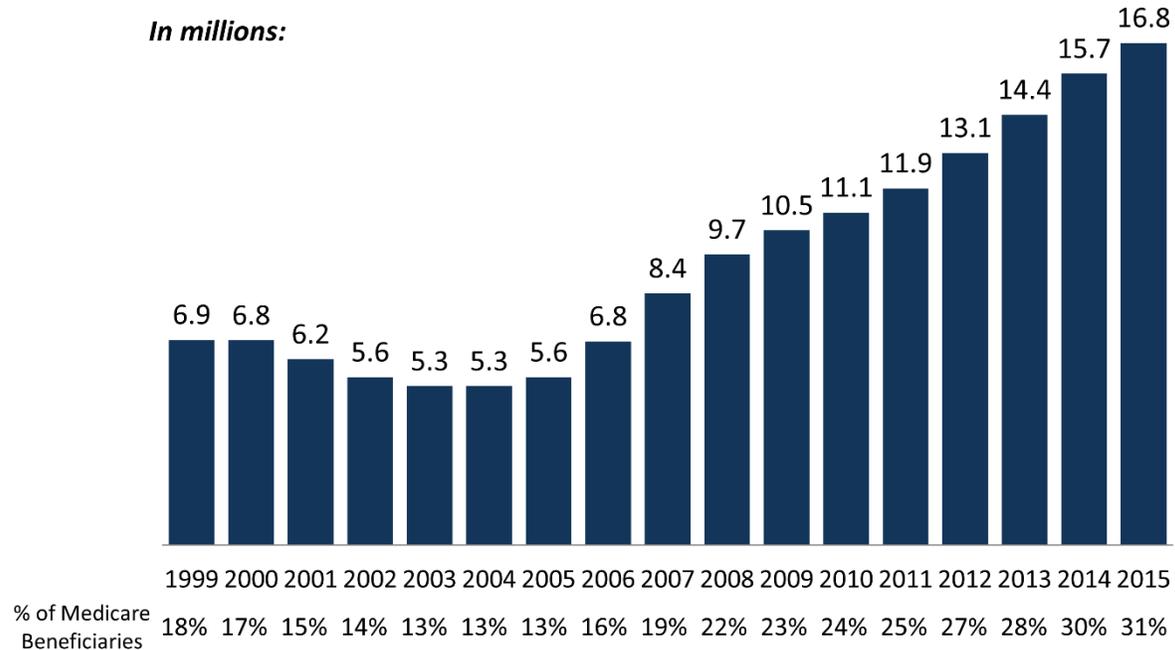
- 23% of large firms that offer health benefits in 2015 also offer retiree benefits compared to 25% in 2014
- 92% offer benefits to early retirees
- 73% offer health benefits to Medicare-age retirees
- 2% offer prescription drug coverage only

Medicare Advantage Enrollment

Figure 1

Total Medicare Private Health Plan Enrollment, 1999-2015

In millions:



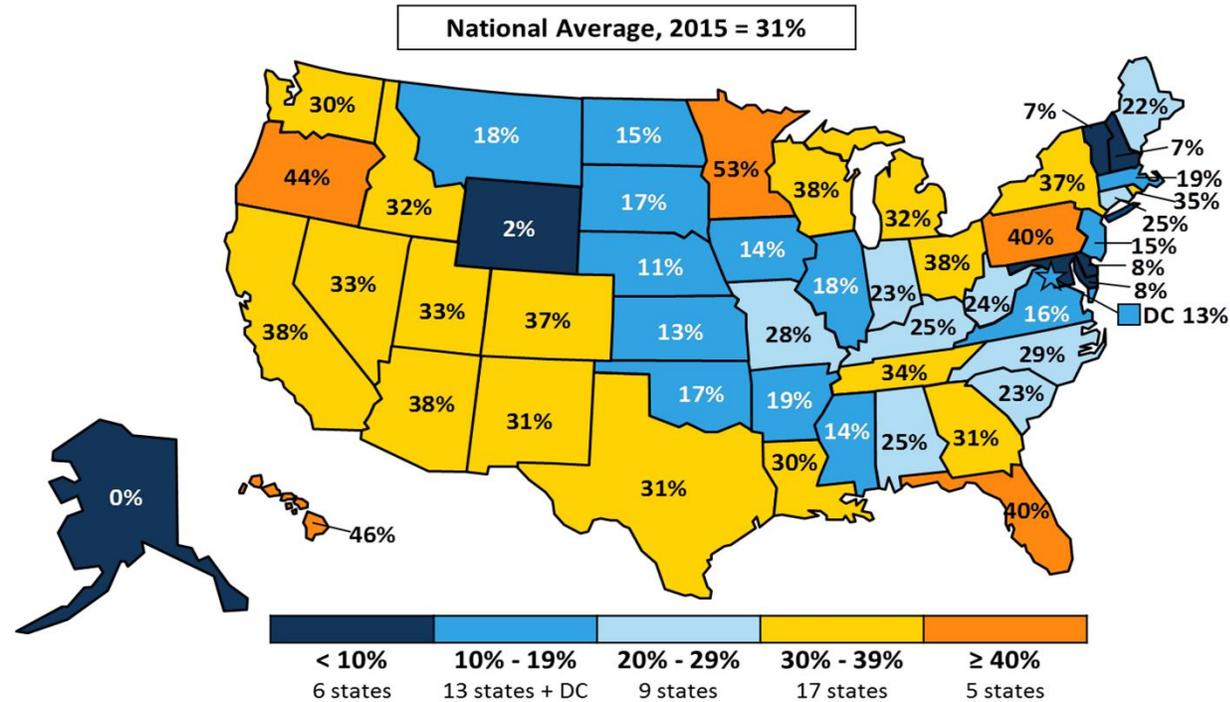
NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2015, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.



Medicare Advantage Penetration

Figure 2

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2015



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
 SOURCE: Authors' analysis of CMS State/County Market Penetration Files, 2015.



Managed Medicaid Managed Medical Assistance (MMA)

- MMA was fully rolled out and Operational as of August 1, 2014
- Details and FAQ for MMA can be found http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml
- There are 17 MMA plans in Florida (2 are Specific to Children)
 - Plans are assigned by Region
- As of January 1, 2016 there are 2,751,574 enrolled in an MMA plan; Enrollment totals for January 1, 2014 was 1,535,908; Growth seen Primarily in Recipients under 21
 - As of January 1, 2016, there were 242,625 Medicaid Only Recipients over 21
- Plans include General Coverage as well as Specialty Plans (Chronic Conditions, HIV, Mental Illness)

Managed Medicaid Managed Medical Assistance (MMA) con't

- MMA in SNFs
 - MMA Plans are Paying for Skilled Nursing Care
 - Contracts Vary Significantly
 - Some Plans will Contract for Services others only offer Letters of Agreement
 - Differences in Payment
 - Levels Based on Skill with or without Outliers
 - RUGs at a Discount
 - Daily Rate
 - Medicaid Room and Board Rate plus Therapy and sometimes Drugs
 - Operationally
 - No 2 Day Notice
 - Discharge Planning is Essential

Operational Impact of Managed Care

- Admissions Process
 - Authorization Process
 - 3 Night Hospital Stay Not Always Required
- Case Management
- Outliers/Carveouts
 - Pharmacy
 - DME
- Discharge Planning
 - Length of Stay Controlled by Plan (Partnership with the plan on LOS and discharges)

Key Financial Differences between Medicare and Medicare Advantage

- Consolidated Billing
 - Must watch for some changes such as with DME - United
- Levels, Daily Per Diem or RUGs
 - Limited to Level based on Plan's Authorization
 - Billing per care and services provided; attaining higher levels
 - Bill per Care and Services Provided
- Carveouts / Exclusions

Future Growth of Managed Care

- Historical and Anticipated growth rates of
 - Medicare Advantage
 - Commercial Insurance
 - Managed Medicaid

Future of Managed Care

- Medicare Advantage Plan Enrollment is continuing to increase across the Country
 - The Number of Medicare Beneficiaries Enrolled in a Private Plan has increased from 5.3 million in 2004 to 16.8 million in 2015 (55 million Medicare Eligibles)
 - 41% of Florida's Medicare Eligibles are in a Medicare Advantage Plan
 - Does not include SnowBirds
 - Highest Penetration Counties: Miami-Dade 64.01%; Osceola 57.68%; Broward 54.09%; Pasco 54.09%; Hernando 52.81%
 - 16 Counties are Greater than 40%
 - 25% of Alabama's Medicare Eligibles are in a Medicare Advantage Plan
 - Does not include SnowBirds
 - Highest Penetration Counties: Chilton 47.11%; Mobile 44.61%; St. Clair 43.54%

Managing Operational Costs

- Managing Ancillary Costs

- Knowing your contract

- Outliers / Exclusions

- Can you bill for pharmacy?
- Can high cost drugs be attained from an outside source?
- Are Labs and X-Ray Services billable or can they be attained from another source?

- Therapy Costs

- Does the Level Assigned Dictate the Amount of Therapy to Provide?
- Are there other aspects of contract that will allow for higher levels outside of therapy?
- Group and Concurrent Therapy
- Communication with Therapy upfront, not after the fact

LEVELS OF CARE*	
Level I Care – Revenue Code 191 \$275	
Nursing Services	Meals
Laboratory Services	Wound Care
Oral Medications	IV administration & fluids
Pain Control	Medical Supplies
Discharge Planning	Ostomy Care – training & supplies
Oxygen – respiratory care	4 units of therapy or less
New & existing tube feedings <i>(including nutrition and supplements)</i>	
Durable Medical Equipment* <i>(see exclusions)</i>	
Simple Radiology Services* <i>(see exclusions)</i>	
Level II Care – Revenue Code 192 \$350	
<i>All Level I services plus</i>	
Tracheostomy care	TPN Administration
Up to 8 units of therapy	Vascular Access
Level III Care – Revenue Code 193 \$575	
<i>All Level I & II services and unlimited therapy units</i>	
Ventilation Support and Dialysis	

***Exclusions:**

Care provided in the Facility does not include professional fee;, transportation; all intravenous meds and supplies, antibiotics; chemotherapy agents (including blood stimulating products); complicated IV insertion (central lines, midlines and PIC lines); any individual drug costing above \$20/day or drugs totaling over \$50 per day; prosthetics and orthotics; specialized beds and non-standard bariatric lifts; MRIs, CTs, PET and, Nuclear Medicine and daily or high cost labs, wound vacs, CPM machine, Dialysis.

Service	Level I \$250	Level II \$330	Level III \$370	Level IV \$445	Level V \$550
24 Hour Nursing	X	X	X	X	X
Direct Skilled	1-2 hours	2-3 hours	3-4- hours	4-5 hours	X
Tube Feedings/ PIC lines	X	X	X	X	X
non-complex colostomy/ileostomy care	X	X			
complex colostomy/ileostomy care			X	X	X
Complex Wound Care (including Decubitus Care)	X Simple wound care, stages 1 and 2 only	X (simple wound care, superficial)	X 1 Treatment/day	X 1 Treatment/day	X
IV therapy (non TPN)		X	X	X	X
Total Parenteral Nutrition Administration			X	X	X
Physical Therapy		X Combined max of 6 units per day	X Combined max of 8 units per day	X Combined max of 12 units per day	X Combined max of 12 units per day
Occupational Therapy		X Combined	X Combined	X Combined max	X Combined

Using Internal Tools with Managed Care

- CMS requires RUG scores to be listed on all Medicare Advantage Claims
- MDSs for all Skilled Members ensures potential to bill Medicare if there are changes in Payer Sources
 - Example: Facility thought payer source was a commercial insurance product, however, after denials, it was determined that Medicare was the payer; no MDS to fall back on.

What does a Managed Care Plan Expect from SNFs?

- Understanding of the Admissions Process
 - Authorizations vs. Notifications
- Communication
 - Updating the Plan with therapy and nursing notes per their requests
 - Sending Relevant Information
 - Don't send the entire chart
 - Notifying the Plan of any Significant Changes
 - Addition of Therapy Discipline
 - Does the request for additional discipline supported by admitting diagnosis?
 - Significant Health Changes
 - RTH, Death
 - Updates on Dr.'s Appointments and Status
 - Members Discharging Early
 - Discharge Planning Upon Admission
 - Accurate NOMNCs sent back to the Plan

Recognizing Key Documentation Areas for Skilled Managed Care Contracts

- How Nursing and Therapy documentation is important to Managed Care
 - Documentation is how a Plan determines the continuation of services or not
 - Insufficient Documentation will lead to an Early Discharge
 - Must paint a complete Picture of the Member
 - Perhaps progress is not as fast as anticipated, but there are comorbidities
 - Is Nursing Skill also being presented?
- What the Managed Care Plans are looking for in Documentation and what is often missing.
 - Stair Training
 - Does Therapy show Contact Guard with Verbal Cues yet Nursing is a two person assist?
 - Complete Wound Care and other Nursing Skill is not always provided
 - Wound Report with Staging and Plan of Treatment

Recognizing Key Documentation Areas for Skilled Managed Care Contracts con't

- Is Nursing taking Credit for Everything they are doing?
- Is there Solid Documentation to Match the Levels Defined in the Contract?
 - What is the Definition of the Level in the Contract?
 - Is there Daily Documentation to show proof of that Level?
 - Using the MARs and TARs to Capture Daily Documentation
 - PICC Line Maintenance
 - Isolation

Recognizing Key Documentation Areas for Skilled Managed Care Contracts con't

- How to best respond to Managed Care Audits.
 - Understanding the request
 - Providing all Requested Documentation and Then Some
 - Making sure the Auditor is referencing your Contract
 - Paper vs Faxing vs Electronic
 - Responding to Unfavorable Determinations
 - Ask for Detailed Denial
 - Provide a Detailed Response with Proof of Services Provided

Recognizing Common Billing Issues for Skilled Managed Care

- Best Practices
- Most Common Billing Errors
- Resolving Claims and Payment Issues

Understanding the Five Star Quality Rating System Design For Nursing Home Compare

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Director of Clinical Reimbursement

March 23rd, 2015

Objectives

Objectives

- Provide a background of the five-star rating
- Review the three measures that comprise the overall five-star rating
- Describe the methodology for constructing the ratings
- Describe the scoring rules for each domain/measure
- Discuss the overall scoring rules for the five-star rating
- Discuss factors that might change a facility's rating
- Describe the impact of the Five Star rating related to Managed Care and ACOs.
- Discuss future QMs planned for the Five Star rating

Background

Background

- 2008- CMS enhances its Nursing Home Compare website
- Develops rating system in form of “stars”
- Purpose- To enhance resident and family’s ability to assess as well as compare Nursing Home Quality

Background

- February 2015- The Five Star system makes the following changes:
 - ❑ Changed Staffing Domain “Cut Table”
 - ❑ Added two QMs to the QM Domain (LS and SS Antipsychotics)
 - ❑ Changed QM Domain “Cut Table” and Calculation Rules

Nursing Home Compare Website

Nursing Home Compare Website

- The Nursing Home Compare website displays each domain individually as well as the overall five-star rating
- Each domain calculates an individual five star rating in addition to the overall five star rating
- Please refer to URL:
<http://www.medicare.gov/nursinghomecompare/?AspxAutoDetectCookieSupport=1>

Nursing Home Compare Website

Star rating summary	
Overall rating ⓘ	 Much Above Average
Health inspection ⓘ	 Average
Staffing ⓘ	 Above Average
Quality measures ⓘ	 Much Above Average

Example Five Star Overview

Example Five Star Overview

- The Overall Rating builds upon the Health Inspection Domain of 3 stars.
- Staffing Domain of 4 Stars adds 1 star towards the Overall rating.
- QM Domain of 5 Stars adds 1 Star towards the Overall rating.
- 3 Stars (Health Inspection) + 1 Star (Staffing) + 1 Stars (QM) = 5 Stars

Example Five Star Overview



Ratings

Methodology for Constructing the Ratings

- Based on the five-star rating for the health inspection domain, the direct care staffing domain and the MDS quality measure domain, the overall five-star rating is assigned in five steps as follows:
 - ❑ **Step 1:** Start with the health inspection five-star rating.
 - ❑ **Step 2:** Add one star to the Step 1 result if staffing rating is four or five stars and greater than the health inspection rating; subtract one star if staffing is one star. The overall rating cannot be more than five stars or less than one star.

Methodology for Constructing the Ratings

- ❑ **Step 3:** Add one star to the Step 2 result if quality measure rating is five stars; subtract one star if quality measure rating is one star. The overall rating cannot be more than five stars or less than one star.
- ❑ **Step 4:** If the Health Inspection rating is one star, then the Overall Quality rating cannot be upgraded by more than one star based on the Staffing and Quality Measure ratings.
- ❑ **Step 5:** If the nursing home is a Special Focus Facility (SFF) that has not graduated, the maximum Overall Quality rating is three stars.

Methodology for Constructing the Ratings

Sample Overall Quality Rating Calculations

Health Inspection Rating	Staffing Rating	Quality Measure Rating	Overall Rating
			
Calculation: 3 stars - 1 star + 0 = 2 stars			
			
Calculation: 3 stars + 1 star + 0 = 4 stars			
			
Calculation: 2 stars + 0 + 0 = 2 stars			

First Domain Health Inspections

- Measures based on outcomes from State health inspections
- Ratings based on the number, scope, and severity of deficiencies identified during the three most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations
- Deficiency findings are weighted by scope and severity
- Takes into account the number of revisits required to ensure that deficiencies identified during the health inspection survey have been corrected

Methodology for Constructing the Ratings

Health Inspection Domain

- Based on the most recent three standard surveys; and
- Results from any complaint investigations during the most recent three-year period; and
- Any repeat revisits needed to verify that required corrections have brought the facility back into compliance

Methodology for Constructing the Ratings

Health Inspection Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points* (75 points)	K 100 points* (125 points)	L 150 points* (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for minimal harm	A 0 point	B 0 points	C 0 points

Note: Figures in parentheses indicate points for deficiencies that are for substandard quality of care. Shaded cells denote deficiency scope/severity levels that constitute substandard quality of care if the requirement which is not met is one that falls under the following federal regulations: 42 CFR 483.13 resident behavior and nursing home practices; 42 CFR 483.15 quality of life; 42 CFR 483.25 quality of care.

* If the status of the deficiency is "past non-compliance" and the severity is Immediate Jeopardy, then points associated with a 'G-level" deficiency (i.e. 20 points) are assigned.

Source: Centers for Medicare & Medicaid Services

Methodology for Constructing the Ratings

Weights for Repeat Revisits

Revisit Number	Noncompliance Points
First	0
Second	50 percent of health inspection score
Third	70 percent of health inspection score
Fourth	85 percent of health inspection score

Note: The health inspection score includes points from deficiencies cited on either the standard annual survey or complaint surveys during a given survey cycle.

Methodology for Constructing the Ratings

Calculation of the Health Inspection Domain Score

- More recent surveys are weighted more heavily than earlier surveys
- Most recent period (cycle 1) is assigned a weighting factor of 50%
- Previous period (cycle 2) has a weighting factor of 33.33%; and
- Second prior survey (cycle 3) has a weighting factor of 16.667%
- Weighted time period scores are then summed to create the survey score for each facility

Health Inspection “Cut Table”

“Cut Point” Table for Health Inspection Domain

Star Cut Points for Health Inspection Scores – by State – (01-01-2016)

Health Inspection Score									
State	Number Of Facilities	1 Star	2 Stars		3 Stars		4 Stars		5 Stars
			Upper	Lower	Upper	Lower	Upper	Lower	
Florida	688	>53.333	≤53.333	>32.667	≤32.667	>20.667	≤20.667	>10.667	≤10.667

Health Inspection Domain Calculation

Example Facility Health Inspection Calculation

	Standard Survey	Points	Cycle 1	Standard Survey	Points	Complaint Survey	Points	Complaint Survey	Points	Cycle 2	Standard Survey	Points	Cycle 3	Total Weighted Points
Tags	6/12/2015			3/14/2014		10/24/2014		8/14/2014			1/17/2013			
	4 Level D	16		1 Level C	0	1 Level D	4	1 Level D	4		6 Level D	24		
	1 Level E	8		3 Level D	12	1 Level E	8				1 Level F	16		
				1 Level E	8									
Pre-weighted Score		24			20		12		4	36		40		
Weighted Score			12.000							12.000			6.667	30.667

Star Cut Points for Health Inspection Scores – by State – (01-01-2016)

Health Inspection Score									
State	Number Of Facilities	1 Star	2 Stars		3 Stars		4 Stars		5 Stars
			Upper	Lower	Upper	Lower	Upper	Lower	
Florida	688	>53.333	≤53.333	>32.667	≤32.667	>20.667	≤20.667	>10.667	≤10.667

Second Domain Nurse Staffing

- Measures based on nursing home staffing levels
- Ratings on the staffing domain are based on two measures:
 1. RN hours per resident day; and
 2. Total staffing hours (RN+ LPN+ nurse aide hours) per resident day
- Does not include other nursing home staff
- The source data for the staffing measures is CMS form CMS-671 from CASPER.

Second Domain Nurse Staffing

- The resident census is based on the count of total residents from CMS form CMS-672 (Resident Census and Conditions of Residents).
- CMS will continue to require providers to submit Forms CMS 671 & CMS 672 at the time of survey. The data from these forms will be used in calculating the Staffing Domain of the Five Star Rating System until late 2017 or early 2018.
- Data from the Payroll Based Journal Electronic Submission System will then be used to calculate the Staffing Domain.

Second Domain Nurse Staffing

- Uses the following formula:
Hours Adjusted = (Hours Reported/Hours Expected) * Hours National Average. Expected hours calculated using facility Case Mix (based on RUGS III-53 groupers).

National average hours per resident per day used in calculation of adjusted staffing (as of April 2012)

Type of Staff	National Average Hours Per Resident Per Day
Total Nursing Staff (Aides & LPN's & RNs)	4.0309
Registered Nurses	0.7472

Second Domain Nurse Staffing

- Casper data includes facility employees (full and part time) as well as contract employees
- Casper data excludes private duty, Hospice staff and feeding assistants
- A set of exclusion criteria identifies facilities with unreliable CASPER staffing data. Neither staffing data nor a staffing rating are reported for these facilities
- The exclusion criteria intends to identify facilities with unreliable CASPER staffing data and facilities with outlier staffing levels

Second Domain Nurse Staffing

Staffing Points and Rating (updated February 2015)

RN Rating and Hours		Total Nurse Staffing Rating and Hours (RN, LPN, and Nurse Aide)				
		1	2	3	5	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥4.418
1	<0.283	★	★	★★	★★	★★★★
2	0.283 – 0.378	★	★★	★★★	★★★	★★★★
3	0.379 – 0.512	★★	★★★	★★★	★★★★	★★★★★
4	0.513 – 0.709	★★	★★★	★★★★	★★★★	★★★★★
5	≥0.710	★★★★	★★★★	★★★★	★★★★	★★★★★

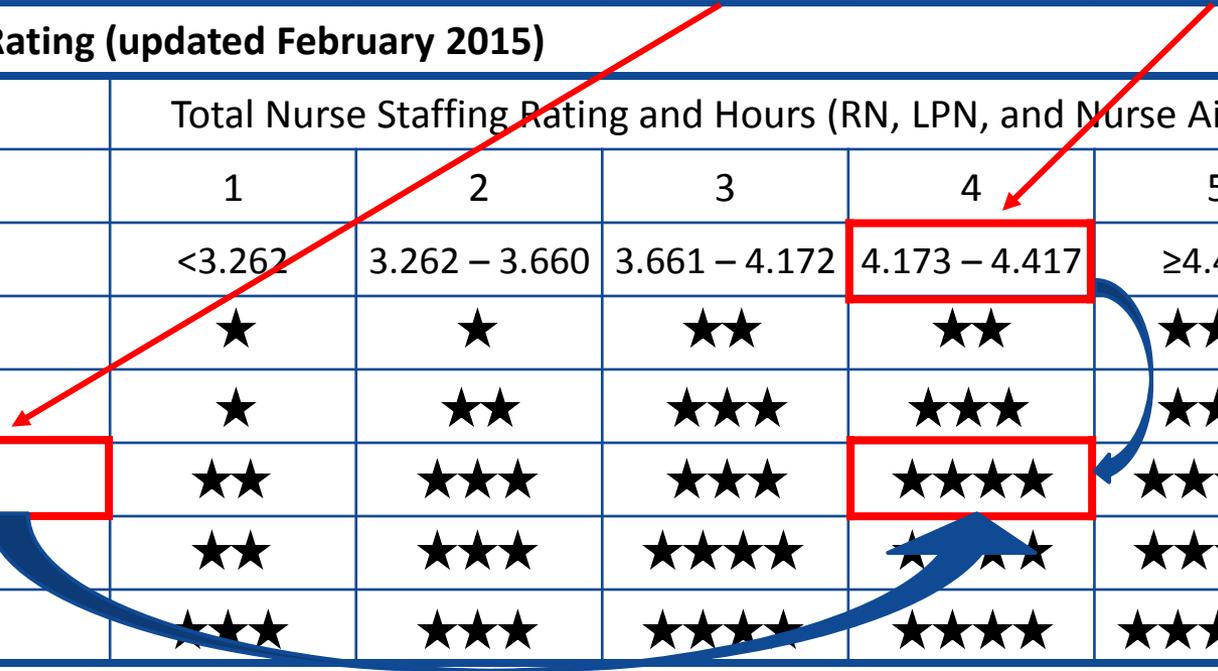
Example Facility Staffing Calculation

Adjusted Hours Per Resident Per Day

Provider Name	Adj. LPN	Adj. RN	Adj. Nurse	Adj. Total
	1.3407328	0.3923653	1.4742169	4.2202292

Staffing Points and Rating (updated February 2015)

RN Rating and Hours		Total Nurse Staffing Rating and Hours (RN, LPN, and Nurse Aide)				
		1	2	3	4	5
		<3.262	3.262 – 3.660	3.661 – 4.172	4.173 – 4.417	≥4.418
1	<0.283	★	★	★★	★★	★★★
2	0.283 – 0.378	★	★★	★★★	★★★★	★★★★
3	0.379 – 0.512	★★	★★★	★★★★	★★★★★	★★★★★
4	0.513 – 0.709	★★	★★★	★★★★	★★★★★	★★★★★
5	≥0.710	★★★	★★★★	★★★★★	★★★★★	★★★★★



Calculation Needed To Attain Five Stars

➤ Step 1 - RN Staffing Calculation

CURRENT RN ADJUSTED HOURS=	0.392365252
FIVE STAR THRESHOLD FOR RN ADJUSTED HOURS =	0.710
ADJUSTED HOURS = REPORTED HRS. / EXPECTD HOURS X NATIONAL AVE.	
PROJECTED RN HRS. NEEDED TO ATTAIN FIVE STAR THESHOLD	1.123000000
EXPECTED RN HOURS =	1.18191457
PROJECTED RN HRS / EXPECTED HOURS	0.950153275
PROJECTED RN HRS / EXPECTED HOURS X NATIONAL AVERAGE (.7472)	0.710
CURRENT REPORTED RN HOURS	0.62064
DIFFERENCE BETWEEN REPORTED HRS AND PROJECTED HRS NEEDED	0.502360000
% INCREASE RN HRS NEEDED TO ATTAIN FIVE STAR THRESHOLD	80.94%

Calculation Needed To Attain Five Stars

➤ Step 2 - LPN Hours Needed

FIVE STAR THRESHOLD FOR TOTAL ADJUSTED HOURS =	4.418
PROJECTED RN HRS. NEEDED TO ATTAIN FIVE STAR THRESHOLD	1.123000000
CURRENT REPORTED AIDE HOURS	3.05367
CURRENT REPORTED LPN HOURS	1.14862
TOTAL PROJECTED REPORTED HOURS IF RN STAFFING IS INCREASED TO FIVE STAR THRESHOLD	5.325290000
TOTAL ADJUSTED HOURS = REPORTED HOURS / EXPECTED HOURS X NATIONAL AVE. (4.0309)	
TOTAL EXPECTED HOURS =	4.606562306
TOTAL PROJECTED REPORTED HOURS IF RN STAFFING IS INCREASED / EXPECTED HOURS =	1.156022571
TOTAL PROJECTED REPORTED HOURS IF RN STAFFING IS INCREASED / EXPECTED HOURS X NATIONAL AVE (4.0309)	4.659811381
TOTAL ADJUSTED HOURS (PROJECTED) EXCEEDING FIVE STAR THRESHOLD IF RN STAFFING IS INCREASED	0.241811381
(MINIMUM) LPN HOURS NEEDED TO ATTAIN FIVE STAR THRESHOLD IF RN STAFFING IS INCREASED	0.6002858
DIFFERENCE BETWEEN MINIMUM LPN HOURS NEEDED AND CURRENT LPN HOURS IF RN STAFFING IS INCREASED	0.54833
% LPN HOURS DECREASED TO ATTAIN FIVE STAR THRESHOLD IF RN STAFFING IS INCREASED	47.74%

QM Domain

- Measures based on the Minimum Data Set (MDS) 3.0 QMs
- Ratings for the QM domain are based on performance on 11 of the 18 QMs
- 8 Long Term QMs
- 3 Short Stay QMS

- Facility rating for the QM domain is based on performance on a subset of 11 (out of 18) of the QMs-MDS 3.0 based

8 Long-Stay QMs

1. Percent of residents whose need for help with activities of daily living has increased
2. Percent of high risk residents with pressure sores
3. Percent of residents who have/had a catheter inserted and left in their bladder
4. Percent of residents who were physically restrained
5. Percent of residents with a urinary tract infection
6. Percent of residents who self-report moderate to severe pain
7. Percent of residents experiencing one or more falls with major injury
8. Percent of residents who received an antipsychotic medication

3 Short-Stay Resident QMs

1. Percent of residents with pressure ulcers (sores) that are new or worsened
2. Percent of residents who self-report moderate to severe pain
3. Percent of residents who newly received an antipsychotic medication

QM Domain

- Values for three of the QMs (catheter, the long-stay pain measure, and short-stay pressure ulcers) are risk adjusted, using resident-level covariates that adjust for factors associated with differences in the score for the QM
- The risk-adjusted QM score is adjusted for the specific risk for that QM in the nursing facility and is described in more detail in the Quality Measure Users Manual available on the CMS website: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/downloads/mds30qm-manual.pdf>
- Ratings for the QM domain are calculated using the three most recent quarters for which data are available

QM Domain Scoring Rules

- Long-stay measures are included in the score if the measure can be calculated for at least 30 assessments (summed across three quarters of data to enhance measurement stability)
- Short-stay measures are included in the score only if data are available for at least 20 assessments
- For each measure, 20 to 100 points are assigned based on facility performance
- Facilities achieving the best possible score on the QM (i.e. 0 % of residents triggering the QM) are assigned 100 points

QM Domain Scoring Rules

- The remaining facilities are assigned 20 to 80 points, based on national percentiles of the QM distribution for providers with values greater than 0%
- The adjusted three-quarter QM values for each of the 9 QMs used in the 5-star algorithm are computed as follows:

$$\text{QM3Quarter} = [(\text{QM Q1} * \text{DQ1}) + (\text{QM Q2} * \text{DQ2}) + (\text{QM Q3} * \text{DQ3})] / (\text{DQ1} + \text{DQ2} + \text{DQ3}) ;$$

QM Domain Scoring Rules

- Where QM Q1, QM Q2, and QM Q3 correspond to the adjusted QM values for the three most recent quarters and DQ1, DQ2, and DQ3 are the denominators (number of eligible residents for the particular QM) for the same three quarters.
- For each QM, the result of this formula provides a **QM value** (i.e. 0.XXXXX) where a **point value** (20-100 Points) is assigned (please see pages 22-25 of the Technical user's manual).

QM Domain Scoring Rules

- All of the 11 QMs are given equal weight. The points are summed across all QMs to create a total score for each facility. The total possible score ranges between 225 and 1100 points. The percentiles are based on the national distribution for all of the QMs except for the ADL measure.

QM “Cut Point” Table

Star Cut-points for MDS Quality Measure Summary Score (updated February 2015)

QM Rating	Point Range for MDS Quality Measure Summary Score (updated February 2015)
★	225 – 544
★★	545 – 629
★★★	630 – 689
★★★★	690 – 759
★★★★★	760 – 1,100

QM Calculation Facility Example

Long Stay	QM Value	Points	Star Cut-points for MDS Quality Measure Summary Score (updated February 2015)	
ADL	0.120967760	60	QM Rating	Point Range for MDS Quality Measure Summary Score (updated February 2015)
HR PU	0.050279350	60		
Catheter	0.045376810	40		
Restraints	0.000000000	100		
UTI	0.020304570	100		
Pain	0.013253670	100		
Falls w/ MI	0.028985510	60		
Antipsychotic	0.245098060	40		
Short Stay				
PU New or Worse	0.011579580	50	★	225 – 544
Pain	0.122807740	80	★★	545 – 629
Antipsychotic	0.009873080	80	★★★	630 – 689
			★★★★	690 – 759
			★★★★★	760 – 1,100
Total		770		



Example Facility QM Comparison

	Facility		Florida Average	National Average
Percent of short-stay residents who self-report moderate to severe pain. <i>Lower percentages are better.</i>	12.3% 		14.7%	17.6%
Percent of short-stay residents with pressure ulcers that are new or worsened. <i>Lower percentages are better.</i>	1.2% 		0.6%	1.0%
Percent of short-stay residents who newly received an antipsychotic medication. <i>Lower percentages are better.</i>	1.0% 		2.7%	2.3%
Percent of long-stay residents experiencing one or more falls with major injury. <i>Lower percentages are better.</i>	2.9% 		2.8%	3.3%
Percent of long-stay residents with a urinary tract infection. <i>Lower percentages are better.</i>	2.0% 		5.4%	5.3%

Example Facility QM Comparison

	Facility	Florida Average	National Average
Percent of long-stay residents who self-report moderate to severe pain. <i>Lower percentages are better.</i>	1.3% 	5.3%	7.6%
Percent of long-stay high-risk residents with pressure ulcers. <i>Lower percentages are better.</i>	5.0% 	5.8%	5.9%
Percent of long-stay residents who have/had a catheter inserted and left in their bladder. <i>Lower percentages are better.</i>	4.5% 	2.8%	3.1%
Percent of long-stay residents who were physically restrained. <i>Lower percentages are better.</i>	0% 	1.2%	1%
Percent of long-stay residents whose need for help with daily activities has increased. <i>Lower percentages are better.</i>	12.1% 	14.3%	15.8%
Percent of long-stay residents who received an antipsychotic medication. <i>Lower percentages are better.</i>	24.5% 	20%	18.6%

Example Facility QM Comparison

- When comparing the example facility's QM percentiles to National and State averages, this facility performs better on eight out of 11 QMs.
- Three QMs of potential focus are:
 1. Short stay residents with pressure ulcers that are new or worsened.
 2. Long stay residents who have had a catheter inserted and left in their bladder.
 3. Long stay residents who received an antipsychotic medication.

Changes In The Five Star Rating

- Facilities may see a change in their overall rating for a number of reasons
- Because the overall rating is based on three individual domains, a change in any one of the domains can affect the overall rating
- A change in a domain can happen for several reasons:
 - ❑ Either New Data for the Facility;
 - ❑ Changes in Data for Other Facilities;
 - ❑ Changes to the methodology calculation; or
 - ❑ Changes to the Cut Table parameters

Changes In The Five Star Rating

- When a facility has a health inspection survey, either standard or as a result of a complaint, the deficiency data from the survey will become part of the calculation for the health inspection rating.
- The data will be included as soon as they become part of the CMS database
- The timing for this may vary but depends on having a complete survey package for the state to upload to the database

Changes In The Five Star Rating

- Additional survey data may be added to the database because of complaint surveys or outcomes of revisits or Informal Dispute Resolutions (IDR) or Independent Informal Dispute Resolutions (IIDR)
- These data may not be added in the same cycle as the standard survey data
- CASPER staffing data are collected at the time of the health inspection survey, so new staffing data will be added for a facility approximately annually

Changes In The Five Star Rating

- The case-mix adjustment for the staffing data is based on MDS assessment data for the current residents of the nursing home on the last day of the quarter in which the staffing data were collected (the survey date).
- If the RUG data for the quarter in which the staffing data were collected are not available for a given facility, the quarter of available RUG data closest to the survey target date - either before or after – is selected

Changes In The Five Star Rating

- The staffing rating calculated using staffing data and RUG data from the same quarter will be held constant for a nursing home until new staffing data are collected for the facility
- Quality Measure data are updated on Nursing Home Compare on a quarterly basis, and the nursing home QM rating is updated at the same time
- The updates occur mid-month in January, April, July, and October
- Changes in the quality measures may change the star rating

Changes In The Five Star Rating

Changes in Data for Other Facilities

- Because the cut points between star categories for the health inspection rating are based on percentile distributions that are not fixed, those cut points may vary slightly depending on the current facility distribution in the database
- However, while the cut points for the health inspection ratings may change from month to month, a facility's rating will not change until there are new survey results for that facility

Five Star Rating Impact on Managed Care & ACOS

- Managed Care & ACOs use to establish networks
- CMS will waive 3 day hospital stay to qualify for SNF stay if SNF has 3 Star or greater rating for:
 - ❑ Hospitals in CCJR model (starting Jan 1st, 2017)
 - ❑ Hospitals in Advanced ACO demonstration

Future QMs Planned for the Five Star Rating

- Five new measures as of July 2016
 - ❑ 1. Percentage of short-stay residents who were successfully discharged to the community (Claims-based)
 - ❑ 2. Percentage of short-stay residents who have had an outpatient emergency department visit (Claims-based)
 - ❑ 3. Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)
 - ❑ 4. Percentage of short-stay residents who made improvements in function (MDS-based)
 - ❑ 5. Percentage of long-stay residents whose ability to move independently worsened (MDS-based)

Future QMs Planned for the Five Star Rating

- This will change the number of quality measures from 11 to 16
- Rebasing the entire QMs again (just like they did in February, 2015)

Future QMs Planned for the Five Star Rating

- Adding quality measures in 2017

- ❑ Staffing turnover and retention
- ❑ Other IMPACT act quality measures (TBD)

For more information on IMPACT act QMs, one may access URL:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014-and-Cross-Setting-Measures.html>

Summary

Summary

- CMS upgraded its Nursing Home Compare website with the Five-Star Quality Rating System to enhance resident and family's ability to assess as well as compare Nursing Home Quality
- The Five-Star Quality System calculates a star-rating for three domains individually: Health Inspection, Staffing, as well as QMs; which comprise the overall composite facility star-rating.
- Each Domain has "Cut Tables," which designate the star-rating on a scale of one to five stars.

Summary

- CMS plans changes to the collection method of staffing data and the implementation of new QMs.
- The ranges on the “Cut Tables” (for each star category) base upon each domain’s score and State or National percentiles
- The first two domains, health Inspection and staffing, have the greatest impact on weighting when calculating the overall rating.
- The data for the star-rating updates with the facility’s standard survey, complaint surveys, as well as revisit surveys

Five Star Help Desk

For questions related to the Five Star rating, one may contact the Five Star Help Desk at: 1-800-839-9290



THANK YOU



NATHAN SHAW, RN, BSN, MBA, LHRM, RAC-CT 3.0
DIRECTOR OF CLINICAL REIMBURSEMENT
RB HEALTH PARTNERS, INC.

We thank you for your time today.

To learn more about this or to discuss services please contact Nathan Shaw at email address nathan@rbhealthpartners.com or visit our web at www.rbhealthpartners.com

March 23rd, 2015

CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 412

Date: DECEMBER 23, 2004

CHANGE REQUEST 3592

SUBJECT: Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished under an “Arrangement” with an Outside Entity

I. SUMMARY OF CHANGES: CLARIFICATION – This instruction provides further clarification of material that was issued on May 21, 2004, in Change Request 3248. It explains that the validity of an arrangement between a Medicare skilled nursing facility (SNF) and its supplier is determined by their actual compliance with the requirements that govern such arrangements, rather than by the presence or absence of specific supporting written documentation. However, while an SNF and its supplier need not execute a formalized legal contract in order to enter into a valid arrangement, developing supporting documentation that reduces to writing the arranged-for services for which the SNF assumes responsibility (and the manner in which the SNF will pay the supplier for those services) can help to ensure that the two parties arrive at a mutual understanding on these points.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 21, 2004

***IMPLEMENTATION DATE: January 24, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	6/Table of Contents
R	6/10.4/ Furnishing Services that are Subject to SNF Consolidated Billing Under an “Arrangement” with an Outside Entity
R	6/10.4.1/ “Under Arrangements” Relationships
R	6/10.4.2/ SNF and Supplier Responsibilities

***III. FUNDING**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 412	Date: December 23, 2004	Change Request 3592
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SUBJECT: Skilled Nursing Facility (SNF) Consolidated Billing: Services Furnished Under an “Arrangement” With an Outside Entity

I. GENERAL INFORMATION

A. Background: The skilled nursing facility (SNF) consolidated billing provisions (at §§1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A) of the Social Security Act (the Act)) place with the SNF itself the Medicare billing responsibility for most of its residents’ services. “Part A” consolidated billing requires that an SNF must include on its Part A bill almost all of the services that a resident receives during the course of a *Medicare-covered* stay, other than those services that are specifically *excluded* from the SNF’s global prospective payment system (PPS) per diem payment for the covered stay. (These “excluded” services, such as the services of physicians and certain other practitioners, remain separately billable to Part B directly by the outside entity that actually furnishes them.) In addition, “Part B” consolidated billing makes the SNF itself responsible for submitting the Part B bills for any *physical, occupational, or speech-language therapy services* that a resident receives during a *noncovered* stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier) under an “arrangement,” as described in §1861(w) of the Act. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Since the inception of the SNF PPS, several problematic situations have been identified where the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. (In this context, the term “supplier” can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.) As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or 2) A supplier fails to ascertain a beneficiary’s status as an SNF resident when the beneficiary (or another individual acting on the beneficiary’s behalf) seeks to obtain such services directly from the supplier without the SNF’s knowledge.

The absence of a valid arrangement in the situations described above creates confusion and friction between SNFs and their suppliers. Suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill Part B (or other payers such as Medicaid and beneficiaries) directly for the services. In

addition, when ordering or furnishing services “under arrangements,” both parties need to reach a common understanding on the terms of payment; e.g., how to submit an invoice, how payment rates will be determined, and the turnaround time between billing and payment. Without this understanding, it may become difficult to maintain the strong relationships between SNFs and their suppliers that are necessary to ensure proper coordination of care to the Medicare beneficiaries. Whenever possible, SNFs should document arrangements with suppliers in writing, particularly with suppliers furnishing services on an ongoing basis, such as laboratories, x-ray suppliers, and pharmacies. This also enables the SNF to obtain the supplier’s assurance that the arranged-for services will meet accepted standards of quality (under the regulations at 42 CFR 483.75(h)(2), SNFs must ensure that services obtained under an arrangement with an outside source meet professional standards and principles that apply to professionals providing such services).

However, it is important to note that the absence of a valid arrangement does NOT invalidate the SNF’s responsibility to reimburse suppliers for services included in the SNF “bundle” of services represented by the SNF PPS global per diem rate. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. This obligation applies even in cases where the SNF did not specifically order the service; e.g., during a scheduled physician’s visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for “incident to” services.

Finally, while establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties, it is not unreasonable to expect occasional disagreements between the parties that may result in non-payment of a supplier claim. However, it is important to note that there are potentially adverse consequences to SNFs when patterns of such denials are identified. Specifically, all participating SNFs agree to comply with program regulations when entering into a Medicare provider agreement which, as explained below, requires an SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself. Moreover, in receiving a bundled per diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment--and financial responsibility--for the service.

B. Policy: Under an arrangement as defined in §1861(w) of the Act, Medicare’s payment to the SNF represents payment in full for the arranged-for service, and the supplier or practitioner must look to the SNF (rather than to Part B) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service (see the online CMS Manual System at www.cms.hhs.gov/manuals/cmsindex.asp, Publication 100-01 (“Medicare General Information, Eligibility, and Entitlement”), Chapter 5 (“Definitions”), §10.3 (“Under Arrangements”)).

Medicare does not prescribe the actual terms of the SNF’s relationship with its supplier (such as the specific amount or timing of the supplier’s payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a

valid “arrangement” to exist, the SNF must reach a mutual understanding with its supplier as to how the supplier is to be paid for its services. Documenting the terms of the arrangement confers the added benefit of providing both parties with a ready means of resolution in the event that a dispute arises over a particular service. This type of arrangement has proven to be effective in situations where suppliers regularly provide services to facility residents on an ongoing basis; e.g., laboratory and x-ray suppliers, DME suppliers, etc.

If an SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse the supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare’s noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and the regulations at 42 CFR 489.20(s)), the SNF’s provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one of the following two situations.

Problem Scenario 1: An SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.

Based on the inaccurate impression that the resident’s SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and may also improperly bill other insurers and the resident. Then, the supplier only learns of the actual status of the resident’s Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary’s status as an SNF resident and the specific nature of the beneficiary’s SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While we recognize that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but must reimburse the supplier once such an error is called to its attention. If, in the scenario at issue, the SNF refuses to pay the supplier for the service even after being apprised of the inaccuracy of its initial information, the SNF would not be in compliance with consolidated billing requirements. As discussed previously, having supporting documentation in place for the disputed service would not only help to ensure compliance with the consolidated billing requirements, but should also provide a vehicle for resolving the dispute itself.

Of course, the SNF can often prevent such disputes from arising to begin with, simply by ensuring that the supplier receives accurate and timely information about the status of a resident's Medicare-covered SNF stay. The SNF's responsibility to communicate accurate and timely resident information to its supplier is especially important in those instances where a particular portion of an otherwise bundled service remains separately billable to Part B (for example, the professional component that represents a physician's interpretation of an otherwise bundled diagnostic test).

Problem Scenario 2: A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services, and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF "bundle" of services subject to consolidated billing that are furnished to the resident by an outside entity, even in the absence of a valid arrangement with the SNF.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements. For example, while the Medicare law at §1802 of the Act guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to the entire package of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services. SNF staff need to communicate these requirements to beneficiaries and family members upon admission. Further, in providing such advice periodically throughout each resident's stay, the SNF should take particular care to include any resident who is about to leave the facility temporarily, in order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing any services to that beneficiary that are subject to the consolidated billing provision. Further, under the regulations at 42 CFR 489.21(h), the beneficiary cannot be charged for the bundled services.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3592.1	Intermediaries and carriers shall notify affected providers of the information contained in this document through the methods described in section I.C. above.	Intermediaries and carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: May 21, 2004	These instructions shall be implemented within your current operating budget.
Implementation Date: January 24, 2004	
Pre-Implementation Contact(s):	

Bill Ullman at (410) 786-5667 or
BUllman@cms.hhs.gov, or
Sheila Lambowitz at (410) 786-7605 or
SLambowitz@cms.hhs.gov

Post-Implementation Contact(s):

Appropriate Regional Office

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing

Table of Contents

(Rev. 412, 12-23-04)

10.4.1 - "Under Arrangements" Relationships

10.4 - Furnishing Services that are Subject to SNF Consolidated Billing Under an “Arrangement” With an Outside Entity

(Rev. 412, Issued: 12-23-04, Effective: 05-21-04, Implementation: 01-24-05)

As discussed in §10.1 and §10.3, the skilled nursing facility (SNF) consolidated billing provisions (at §1862(a)(18), §1866(a)(1)(H)(ii), and §1888(e)(2)(A) of the Act) place with the SNF itself the Medicare billing responsibility for most of its residents’ services. “Part A” consolidated billing requires that an SNF must include on its Part A bill almost all of the services that a resident receives during the course of a Medicare-covered stay, other than those services that are specifically excluded from the SNF’s global PPS per diem payment for the covered stay. (These “excluded” services, such as the services of physicians and certain other practitioners, remain separately billable to Part B directly by the outside entity that actually furnishes them.) In addition, “Part B” consolidated billing makes the SNF itself responsible for submitting the Part B bills for any physical, occupational, or speech-language therapy services that a resident receives during a noncovered stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either furnish the service directly with its own resources, or obtain the service from an outside entity (such as a supplier) under an “arrangement,” as described in §1861(w) of the Act and in §80.5. Under such an arrangement, the SNF must reimburse the outside entity for those Medicare-covered services that are subject to consolidated billing; i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Since the inception of the SNF PPS, several problematic situations have been identified where the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. (In this context, the term “supplier” can also include those practitioners who, in addition to performing their separately billable professional services, essentially act as a supplier by also furnishing other services that are subject to the consolidated billing requirement.) As discussed in greater detail below, such situations most commonly arise in one of the following two scenarios: 1) An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier or practitioner; or 2) A supplier fails to ascertain a beneficiary’s status as an SNF resident when the beneficiary (or another individual acting on the beneficiary’s behalf) seeks to obtain such services directly from the supplier without the SNF’s knowledge.

The absence of a valid arrangement in the situations described above creates confusion and friction between SNFs and their suppliers. Suppliers need to understand which services are subject to consolidated billing to avoid situations where they might improperly attempt to bill Part B (or other payers such as Medicaid and beneficiaries) directly for the services. In addition, when ordering or furnishing services “under arrangements,” both parties need to reach a common understanding on the terms of payment; e.g., how to submit an invoice, how payment rates will be determined, and the

turn-around time between billing and payment. Without this understanding, it may become difficult to maintain the strong relationships between SNFs and their suppliers that are necessary to ensure proper coordination of care to the Medicare beneficiaries. Whenever possible, SNFs should document arrangements with suppliers in writing, particularly with suppliers furnishing services on an ongoing basis, such as laboratories, x-ray suppliers, and pharmacies. This also enables the SNF to obtain the supplier's assurance that the arranged-for services will meet accepted standards of quality (under the regulations at 42 CFR 483.75(h)(2), SNFs must ensure that services obtained under an arrangement with an outside source meet professional standards and principles that apply to professionals providing such services).

However, it is important to note that the absence of a valid arrangement does NOT invalidate the SNF's responsibility to reimburse suppliers for services included in the SNF "bundle" of services represented by the SNF PPS global per diem rate. As the SNF has already been paid for the services, the SNF must be considered the responsible party when medically necessary supplier services are furnished to beneficiaries in Medicare Part A stays. This obligation applies even in cases where the SNF did not specifically order the service; e.g., during a scheduled physician's visit, the physician performs additional diagnostic tests that had not been ordered by the SNF; a family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Finally, while establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties, it is not unreasonable to expect occasional disagreements between the parties that may result in non-payment of a supplier claim. However, it is important to note that there are potentially adverse consequences to SNFs when patterns of such denials are identified. Specifically, all participating SNFs agree to comply with program regulations when entering into a Medicare provider agreement which, as explained below, requires an SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself. Moreover, in receiving a bundled per diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment--and financial responsibility--for the service.

Accordingly, these instructions reiterate and clarify the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.

10.4.1 - "Under Arrangements" Relationships

(Rev. 412, Issued: 12-23-04, Effective: 05-21-04, Implementation: 01-24-05)

Under an arrangement as defined in §1861(w) of the Act, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the supplier must look to the SNF (rather than to Part B) for its payment. Further, in entering into such an arrangement, the SNF cannot function as a mere billing conduit, but must actually exercise professional responsibility and control over the arranged-for service (see the

Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, “Definitions,” §10.3, for additional information on services furnished under arrangements).

Medicare does not prescribe the actual terms of the SNF’s relationship with its suppliers (such as the specific amount or timing of payment by the SNF), which are to be arrived at through direct negotiation between the parties to the agreement. However, in order for a valid “arrangement” to exist, the SNF must reach a mutual understanding with its supplier as to how the supplier is to be paid for its services. *Documenting the terms of the arrangement confers the added benefit of providing both parties with a ready means of resolution in the event that a dispute arises over a particular service. This type of arrangement has proven to be effective in situations where suppliers regularly provide services to facility residents on an ongoing basis; e.g., laboratory and x-ray suppliers, DME supplies, etc.*

If an SNF elects to utilize an outside supplier to furnish medically appropriate services that are subject to consolidated billing, but then refuses to reimburse that supplier for the services, then there is no valid arrangement as contemplated under §1862(a)(18) of the Act. Not only would this potentially result in Medicare’s noncoverage of the particular services at issue, but an SNF demonstrating a pattern of nonpayment would also risk being found in violation of the terms of its provider agreement. Under §1866(a)(1)(H)(ii) of the Act (and 42 CFR 489.20(s)), the SNF’s provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision. Further, §1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

10.4.2 - SNF and Supplier Responsibilities

(Rev. 412, Issued: 12-23-04, Effective: 05-21-04, Implementation: 01-24-05)

Problems involving the absence of a valid arrangement between an SNF and its suppliers typically tend to arise in one of the following two situations.

Problem Scenario 1: An SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.

Based on the inaccurate impression that the resident’s SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and may also improperly bill other insurers and the resident. Then, the supplier only learns of the actual status of the resident’s Medicare-covered SNF stay when that

Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While we recognize that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but must reimburse the supplier once such an error is called to its attention. If, in the scenario at issue, the SNF refuses to pay the supplier for the service even after being apprised of the inaccuracy of its initial information, the SNF would not be in compliance with consolidated billing requirements. As discussed previously, having supporting documentation in place for the disputed service would not only help to ensure compliance with the consolidated billing requirements, but should also provide a vehicle for resolving the dispute itself.

Of course, the SNF can often prevent such disputes from arising to begin with, simply by ensuring that the supplier receives accurate and timely information about the status of a resident's Medicare-covered SNF stay. The SNF's responsibility to communicate accurate and timely resident information to its suppliers is especially important in those instances where a particular portion of an otherwise bundled service remains separately billable to Part B (for example, the professional component that represents a physician's interpretation of an otherwise bundled diagnostic test).

Problem Scenario 2: A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services, and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF "bundle" of services subject to consolidated billing that are furnished to the resident by an outside entity, even in the absence of a valid arrangement with the SNF.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements. For example, while the Medicare law at §1802 of the Act guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to the entire package of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services. SNF staff need to communicate these requirements to beneficiaries and family members upon admission. Further, in providing such advice periodically throughout each resident's stay, the SNF should take particular care to include any resident who is about to leave the facility temporarily, in

order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier in this scenario is also responsible for being aware of and complying with the consolidated billing requirements. This means that prior to furnishing services to a Medicare beneficiary, the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services. If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing any services to that beneficiary that are subject to the consolidated billing provision. Further, under the regulations at 42 CFR 489.21(h), the beneficiary cannot be charged for the bundled services.

Advance Care Planning Medicare Billing Codes

The Conversation Project in
Central Florida

The Challenge

- 90 % of Americans believe it is important to have end-of- life care discussions with their families, yet less than 30% have done so.
- Difficult to think about one's own death
- Family uncomfortable raising the subject of their elderly parent or family members death

Failure to Act

- 60% of people say that making sure their family is not burdened by tough decisions is “extremely important” but 56% have not communicated their end-of-life wishes.
- Decisions are made on our behalf by uncertain family members while they are faced with a crisis
- Decision makers are at a higher risk for mental health issues such as depression and anxiety

Patient-Provider Communication

- 80% of people say that if seriously ill, they would want to talk to their doctor about end-of-life care but just 7% report having had such a conversation with their healthcare provider
- 7/10 causes of death in 2010 were due to chronic diseases
- Conversations with healthcare providers provided
- Patient more likely to receive care consistent with preferences
- Better quality of life

Advance Care Planning Medicare Billing Codes

- Medicare has always included ACP in the initial Welcome to Medicare visit – might not need this when first enrolled
- Starting in January 2016 Healthcare Providers can be reimbursed for this Valuable Conversation
- 99497- explanation and discussion of ACP and explanation and completion of forms, first 30 minutes, face to face with the patient family/surrogate
- 99498- This code will cover all the above information that is extended beyond the initial 30 minutes (Add on code)

Advanced Care Planning Medicare Billing Codes

- Medicare beneficiaries who choose to pursue the conversation with their Healthcare Providers will allow these early conversations between patient and their practitioners, before an illness progresses and continue during the course of treatment
- This will allow the patient and family to decide on the type of care that is right for them with guidance from their healthcare practitioner.

Advance Care Planning

- This is really focused on
- It is not about what is the MATTER with you but what MATTERS to you!!!

Tips on Talking

Thinking about having “the Conservation”

Dr L. Furrow wrote:

- ...most hospital systems are designed to keep pumping out treatments, often making it easier for physicians to offer another test or medicine than to have a series of long and often difficult conversations about death with patients.

Insurers ...

Are more likely to pay for the treatments than the
conversation

There is no statistical proof that
doctors enjoy a better quality of
life than the rest of us.

BUT, research indicates they are better planners - they
have advanced directives

How Doctors Die

- At home
- Less aggressive care
- A “gentle death”
- No extraordinary measures when those measures have no meaning.

Most Americans-

Research shows that most Americans do not die the way they say they want to – at home, surrounded by the people who love them.

According to Medicare

- Only one third of patients die at home
- More than 50% spend their final days in hospital, often in intensive care tethered to machines and tubes
- Or in Nursing homes

“Death Foretold”- N. Christakis

- Few physicians even offer patients a prognosis, and when they do they do not do a great job.
- Predictions are often overly optimistic, with doctors being accurate just 20% of the time

**We want YOU to be the
expert on your wishes and
those of your loved ones.**

Not the doctors or nurses ...

Not the end-of-life experts ...

Just YOU

Where I Stand Scales

As a patient...

1

I want my
doctors to
do what
they think is
best

2

3

4

5

I want to
have a say
in every
decision

I'm worried
that I won't
get enough
care

I'm worried
that I'll get
overly
aggressive
care



1

I want to live
as long as
possible, no
matter what

2

3

4

5

Quality of life
is more
important to
me than
quantity

How involved do I want my loved ones to be?

1

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable

2

3

4

5

I want my loved ones to do what brings them peace, even if it goes against what I've said

1

2

3

4

5

I wouldn't
mind being
cared for in
a nursing
facility if
necessary

I want to live
independently,
no matter
what

Having the conversation may reveal:

- That you and your loved ones disagree
- Patience is a virtue
- Some people need more time to think
- You don't have to steer the conversation
- Don't judge
- A “good death” means different things to different people
- You can change your minds as circumstances shift

Icebreakers

- “I need your help with something.”
- “I was thinking about what happened to _____, and it made me realize...”
- “Even though I’m okay right now, I’m worried that _____ and I want to be prepared.”
- “I need to think about the future. Will you help me?”

“How to Talk to your Doctor”

<http://theconversationproject.org/starter-kit>

“Passing the Torch, Critical Conversations with Your Adult Children”

www.giftofcommunication.com

Bob Mauterstock



**Senior
Providers**
RESOURCE, LLC



**Preventing Falls with
Restorative Nursing
&**



Mobility Enhancement Programs

Presented By:

**Jeri Lundgren, RN, BSN, PHN, CWS, CWCN
President**



Senior Providers Resource, LLC





Keeping Residents Mobile

- **Mobility – the ability to efficiently navigate and function in a variety of environments, requires balance, agility and flexibility.**





Clinical Foundation





- **Humans are Meant to be Upright & Mobile**



**Optimal Body Function –
Upright for 16 hours/day**



- **Immobility, potential root cause of the following:**

- Falls
- Skin Breakdown
- Incontinence & UTIs
- Development of diseases – Diabetes, Cardiac, etc.
- Weight loss – muscle wasting
- Depression
- Delirium/confusion
- Respiratory Infections
- Constipation
- Staff injuries





- **Root Cause of Falls**

- **Falls**

- **Strength, Balance and Endurance issue**





- **Impact of Falls**

- Fractures

- 95% from falling, most often by falling sideways
- 1 out of 5 hip fracture patients dies within a year of their injury





- **The Effects of Immobility**
 - Loss of Independence & Psychosocial effects
 - Fear of falling – leading to social isolation





• The Causes of Immobility in the Nursing Home

• Staff

- Residents moving too slow or taking too long
- Restricting them from moving on their own





• The Effects of Immobility – Muscles

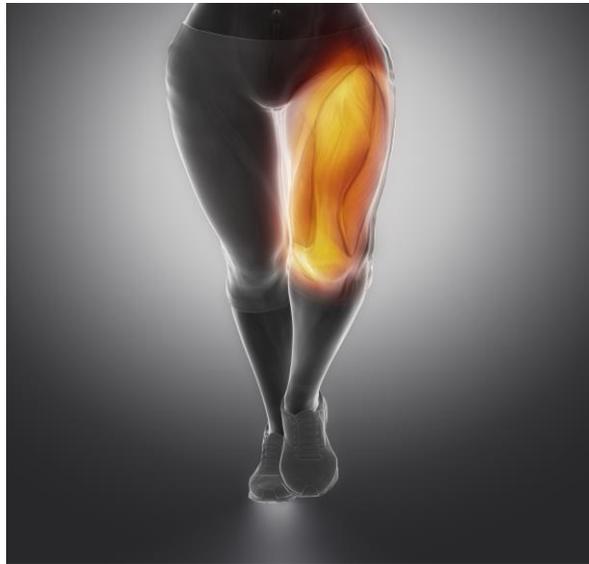
- There is a 12% rate of loss of muscle strength and muscle atrophy (wasting away) in one week
- In as little as 3-5 weeks of immobility, almost half the normal strength of a muscle is lost





• The Effects of Immobility – Muscles

- First muscles to become weak are in the lower limbs
- Keeping a muscle in a contracted position will significantly increase atrophy
- In stroke paralysis or immobility due to splinting, muscles atrophy around 30-40%





• The Effects of Immobility – Muscles

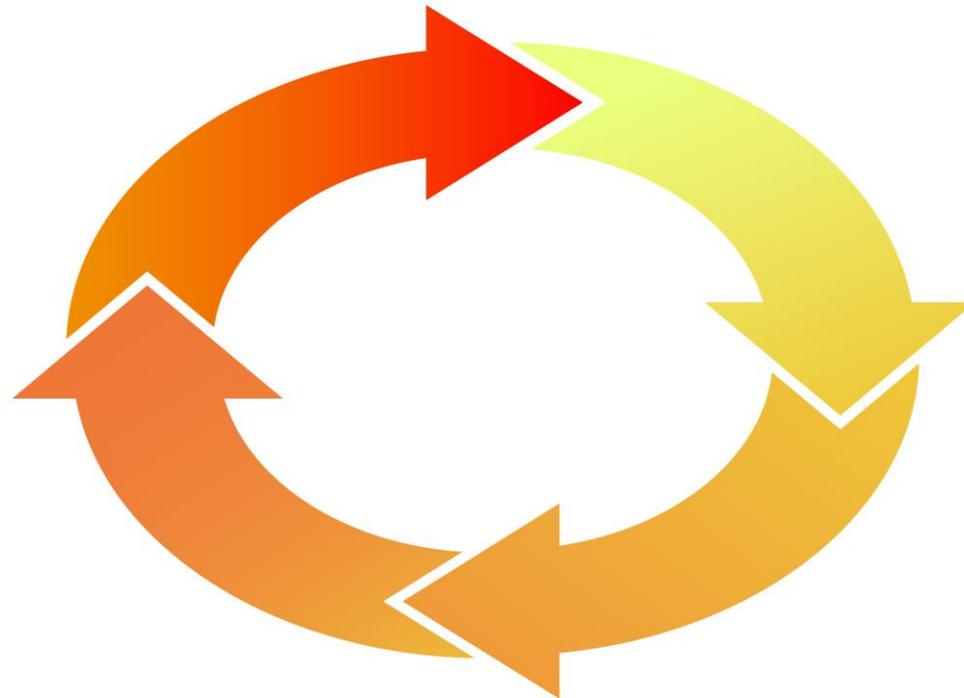
- It takes 4 weeks to recover from atrophy with exercise
- Totally degenerated muscles are permanently replaced by fat and connective tissue
- Disuse of the muscle will also effect the neuromuscular function – essentially the body forgets how to properly coordinate motor function





• The Effects of Immobility – Muscles

- Complete rest will decrease endurance levels
- Causing fatigue, affecting motivation
- Then leading to a cycle of greater inactivity





• **The Effects of Immobility – Connective Tissue**

- Connective tissue consists of:
 - Tendons
 - Ligaments
 - Articular cartilage (covers joints)
- In 4-6 days after immobility changes in the structure and function of connective tissue become apparent
- These changes remain even after normal activity has been resumed!!



• The Effects of Immobility – Contractures

- Contracture:

A decrease from the normal range in parts of the body responsible for motion (joints, ligaments, tendons and related muscles)

- In 2-3 weeks of immobilization a firm contracture can develop
- After 2-3 months of immobility, surgical correction may be needed.





• The Effects of Immobility – Bone

- Disuse osteoporosis
- Bones most susceptible:
 - Vertebra
 - Long bones of the legs
 - Heels
 - Wrists





• The Effects of Immobility – Bone

- Within 3 weeks of immobilization calcium clearance is 4-6 times higher than normal and hypocalcaemia can occur. This can lead to:
 - Formation of calcium-containing kidney stones
 - Anorexia
 - Nausea
 - vomiting





• The Effects of Immobility – Skin

- Normally we continually shift our weight, even during sleep
- Immobility or decreased sensation prevents shifting in weight leading to prolonged pressure on skin capillaries, ultimately resulting in death of skin tissue
- Formation of pressure ulcers





• The Effects of Immobility – Cardiac System

- When an individual is confined to bed, there is a shift of fluids away from the legs towards the abdomen, thorax and head.
- In as little as 24 hours, a shift of 1 liter of fluid from the legs to the chest
- Increases venous return to the heart and elevated intracardial pressure





• The Effects of Immobility – Cardiac System

- Increases in blood volume and venous return stretch the right atrium in the heart
 - Stimulates the release of atrial natriuretic peptide (ANP) a powerful diuretic
 - Increase in urine output
 - Decreases in blood volume
- Leads to dehydration





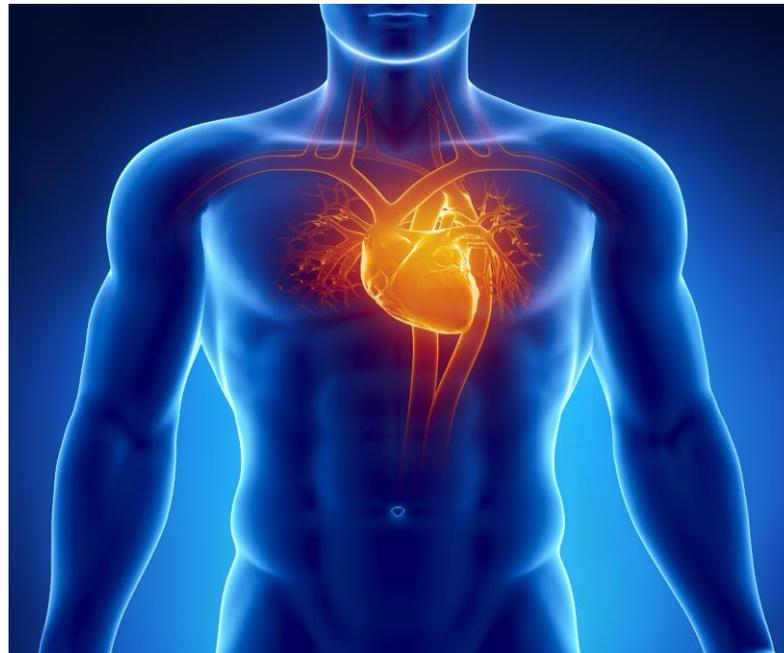
• **The Effects of Immobility – Cardiac System**

- Immobility leads to atrophy and loss of muscle mass in the legs
- This impairs the muscle pump action which reduces venous return
- Lower extremity edema
 - Ulceration
 - Venous dermatitis
 - Cellulitis



• **The Effects of Immobility – Cardiac System**

- The heart is a muscle and too needs activity to stay healthy
- Immobility can lead to atrophy of the heart muscle





• **The Effects of Immobility – Cardiac System**

- Postural hypotension (drop in blood pressure upon standing) can be noted in little as 20 hours of immobility
- This can lead to dizziness, anxiety and falls
- Postural hypotension, even in fit, healthy adults can take several weeks to fully recover once they start moving



• The Effects of Immobility – Respiratory System

- Development of fixed contractures of the costovertebral joints, leading to inability to expand the lungs
- Risk of lung collapsing
- Pooling of mucus in the lower airways
- Increased risk of respiratory infections
 - Stroke patients confined to bed for 13 days or more are 2-3 times more likely to develop a respiratory infection than mobile people





- **The Effects of Immobility – Hematological**

- Decrease in oxygen saturation
- Increase in carbon dioxide concentrations
- Leads to Hypoxia
 - Acute confusion
 - Can develop quickly over a number of hours
 - Symptoms can fluctuate during the day and worsen at night



- **The Effects of Immobility – Hematological**

- 13% of patients in bed for long periods may develop deep vein thrombosis (DVT)
- Increases risk for emboli
 - In the lungs - pulmonary embolism
 - Cerebral circulation within the brain – Stroke
 - Coronary circulation of the heart – myocardial infarction



• The Effects of Immobility – Gastrointestinal

- Reduced sense of taste, smell and loss of appetite
- Difficulty swallowing
- Constipation
- Fecal impaction





• The Effects of Immobility – Endocrine System

- Decrease in metabolic rate
 - In as little as 10 hours
- Insulin resistance, impaired glucose tolerance and the subsequent development of type 2 diabetes





• The Effects of Immobility – Renal System

- Functional Incontinence
- Kidney stones
- Urinary retention (overflow)
- Urinary tract infection
- Urosepsis





• The Effects of Immobility – Nervous System

- Sensory deprivation
- Depression
- Disorientation
- Confusion
- Restlessness
- Agitation/aggression
- Anxiety
- Reduced pain threshold
- Difficulty problem solving
- Loss of motivation





• The Effects of Immobility – Nervous System

- Insomnia
- For normal function we need:
 - 16 hours of activity
 - 7-8 hours of sleep
- Consistently sleeping for more than 9 hours or fewer than eight hours has a negative impact on physiological, psychological and cognitive functions





- **The Aging Process Impact on Mobility**

- **Sarcopenia**

- The loss of muscle mass with age
- Each decade the aging adult has 5lbs less muscle and about 15 pounds more fat
- Resulting in a 20lbs change in physical status and appearance



- **The Aging Process Impact on Mobility**
 - The primary cause of the loss of muscle mass

DISUSE





• The Aging Process Impact on Mobility

- Dieting alone without exercise does not have high success rates
 - 25% percent of weight lost during low calorie diets without exercise is actually lost muscle tissue
 - Less muscle leads to slower metabolism
 - Reduced muscle tissue is largely responsible for a 2 – 5% per-decade decrease in our resting metabolism
 - Slower resting metabolism leads to calories previously used by muscle are routed into fat storage



• **The Aging Process Impact on Mobility**

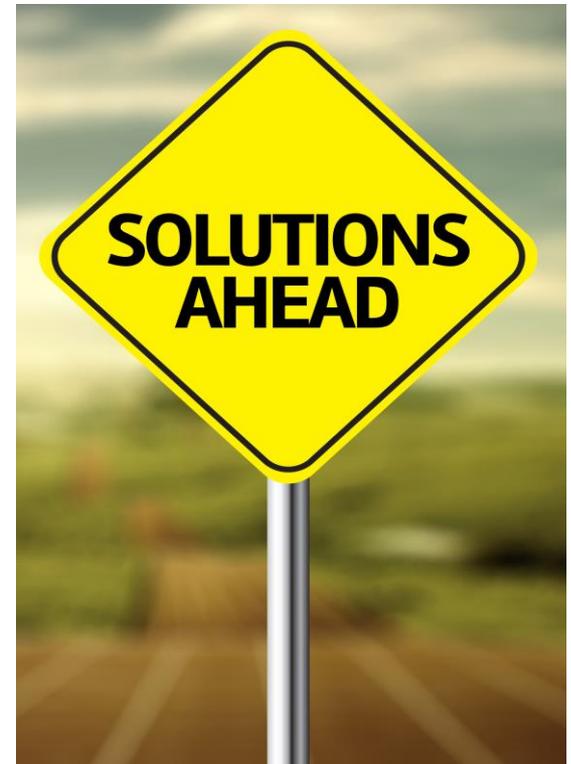
- All adults should perform regular endurance exercise such as walking and cycling to enhance cardiovascular function, However
- Aerobic activities do little to prevent gradual deterioration of the musculoskeletal system
- One study of elite middle-aged runners, the subjects lost about 5lbs of muscle over a 10 year period in spite of extensive aerobic training.



• The Effects of Immobility

The Solution – Strength Training

- Systemic strength training – use of resistance
 - Adding muscle
 - Losing fat
 - Raising resting metabolic rate
 - Increase daily expenditure
 - Increase bone density
 - Enhance glucose metabolism
 - Increase gastrointestinal transit
 - Lower resting blood pressure and pulse
 - Decrease in depression





- **Strength Training Exercise program:**
 - Studies have shown that muscle mass can be increased at essentially any age through systemic strength training even if they have never done strength training before





PREVENT THE EFFECTS OF IMMOBILITY





Governance & Leadership

- Administrator, DON and Management must fully support the program and be actively involved





- **Assess your current Programs to Identify a Starting point**

- What is the mind set of the staff?
- How many of your Residents depend on wheelchairs for mobility?
- What is the relationship between Nursing, Therapy and Activities?
- Do you currently have a Restorative Nursing Program and what does that provide?
- What types of activities do you have during the day and in the evenings?
- Do you have a sleep hygiene program?





- **Get ALL staff on board**
- **Initial Training on WHY???**





Aim Toward Independence
“How to”
Rather than
“Doing for”
You are the coach!!





• Assemble Your Team:

- Therapy
- Restorative Nursing – Lead Nurses and Lead Nursing Assistants
- Nursing assistants – All shifts
- Floor nurses - all shifts
- Nurse Managers/Supervisors
- Physicians/Nurse Practitioners
- Activities
- Dietary
- Maintenance
- Housekeeping



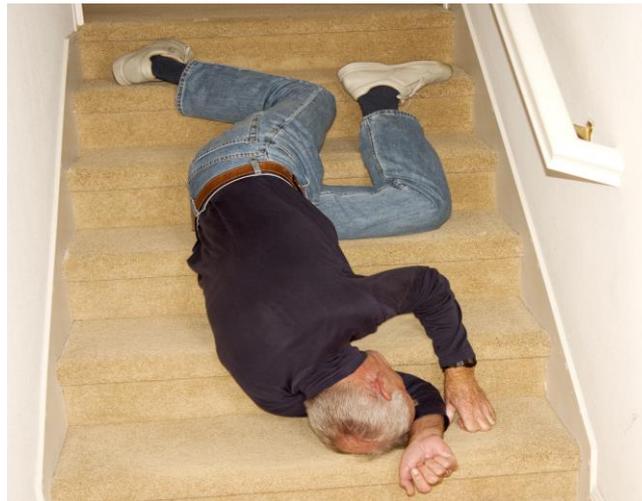


What will be your facility's benchmarking Data?

- **Quality Measures**

- **Long Stay:**

- Percent of Residents Experiencing One or More Falls with Major Injury
 - Falls
 - Activities of Daily Living Has Increased





Environment





• Environment

- Floor surfaces: shiny, slippery, or do the surfaces change in areas (going from carpet to tile)
- Grab bars and hand rails in good condition, clearly identified and throughout the entire building
- Lighting bright no glare
- Clear walkways
- Contrasting colors





- **Environment**

- Devices to promote self repositioning or mobility in resident rooms
 - Low beds ONLY for residents who cannot physical egress at all and roll out of bed
 - Proper width of the bed – wider widths (42 inches) shown to decrease falls
 - Careful use of floor mats



- **Environment**

- Devices to promote self repositioning or mobility in resident rooms – for residents that can egress from bed
- Proper egress height of the bed & mattress – feet flat on the floor with the knees slightly above a 90 degree angle
- Mark the head board with tape for proper position of bed
- Grab bars or transfer poles to stabilize





- **Environment**

- Devices to promote self repositioning or mobility in resident rooms
 - Properly fitted and accessible
 - Wheelchairs
 - Walkers
 - Canes





- **Environment**

- Devices to promote self repositioning or mobility in resident rooms
 - Clear path into the bathroom
 - Lighting at night – amber tones
 - Bathroom environment
 - Contrasting colors
 - Proper toilet seat height
 - Grab bars





- **Environment**

- Stand Assist Devices to promote early mobility and exercise in a standing position dedicated to Therapy & Restorative Nursing





- **Sufficient Resources**
 - Accessible Exercise Equipment
 - Enough for groups of 4





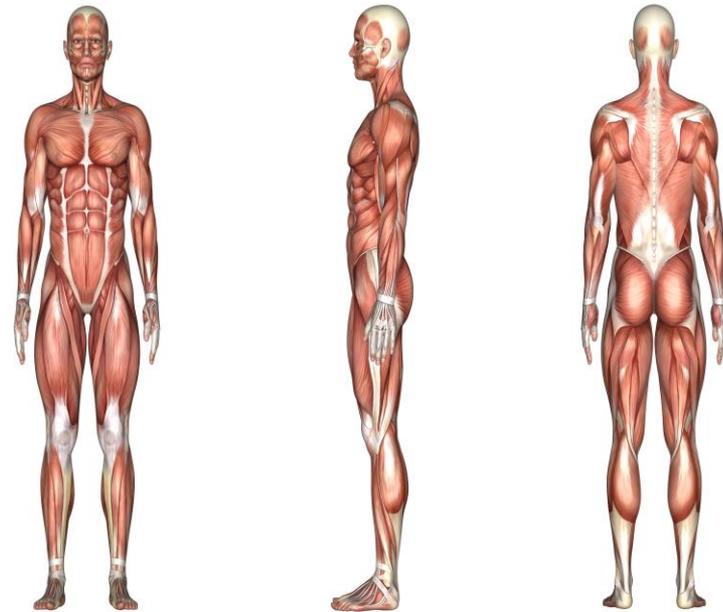
- **Exercise program:**

- Are specifically designed for older adults that can be done individually or in groups of 4 in 15 or 30 minute increments
- Can be done in different positions depending on balance issues
 - Supine Position
 - Sitting Position
 - Standing in an assistive device
 - Standing



- **Develop Exercises that call for exercise for each of the major muscle groups**

- **Quadriceps**
- **Hamstrings**
- **Pectoralis Major**
- **Latissimus Dorsi**
- **Deltoids**
- **Biceps**
- **Triceps**
- **Erector Spinae**
- **Rectus Abdominus**
- **Neck**
- **Flexors/Extensors**





- **Frequency of Strength Training**
 - **Strength exercises may be productively performed two to three days per week**
 - **Allow 48 hours of rest for each muscle/muscle group worked – train upper body muscles and the lower body muscles on alternative days**



• Strength Training

- Proper warm-up and cool down are needed for strength training exercises
 - Simple walking or marching while sitting for standing balance issues
 - Large body movements (arm crosses) for wheelchair bound
 - When warming up no static stretching





• Proper Cool Down - Stretching

• Tips:

- Hold stretches for 30 seconds or more
- Go to the point you feel the muscles stretching
- Do not go past that point where it starts to hurt
- Always ease into a stretch gently





Walking

- **Physical Activity (Steps per day)**

- Public health recommendations of achieving 10,000 steps per day.
- While the physical activity assessment is designed to be a gauge for the resident's physical activity status in the form of ambulation, targets of the following have been associated with higher health related quality of life outcomes:
 - Men: 5,500 steps/day
 - Women: 4,500 steps/day





Walking

- **Physical Activity (Steps per day)**

- A 10-minute walk is approximately comparable to 1,000 steps, depending on walking speed and stepping cadence. Adding 100 to 1,000 steps per day or week may enable residents to achieve recommendations.
- Those residents who are capable may work up to the 10,000 steps per day recommendations.





- **Exercises for specific conditions/concerns**
 - **Alzheimer's Disease**
 - **Amyloid plaques in the brain**
 - **Interventions to decrease amyloid plaques**
 - **Adequate sleep**
 - **Exercise**

Guest Column in McKnights:

http://www.mcknights.com/guest-columns/lifestyle-and-the-aging-brain/article/417260/?DCMP=EMC-MCK_Daily&spMailingID=11530562&spUserID=ODE2NDE0MDMwNDES1&spJobID=560074336&spReportId=NTYwMDc0MzM2S0



- **Exercises for specific conditions/concerns**

- **Parkinson Disease**

- **Mobility – the ability to efficiently navigate and function in a variety of environments, requires balance, agility and flexibility all of which are affected by Parkinson Disease.**
- **Rigidity, bradykinesia, freezing, poor sensory integration, inflexible program selection and impaired cognitive processing limit mobility in people with Parkinson Disease.**





- **Exercises for specific conditions/concerns**
 - **Parkinson Disease**
 - **Obstacle Courses**
 - **Kayaking**
 - **Lunges**
 - **Kicks**
 - **Quick Boxing Movement**



- Exercises for specific conditions/concerns
 - Parkinson Disease
 - Tai Chi





- **Exercises for specific conditions/concerns**
 - **Cognitive Impairment**
 - Inability to simultaneously carry out a cognitive task and a balance or walking task has been found to be a predictor of falls in elderly people.
 - Agility program could progress task difficulty by adding cognitive or motor tasks that teach residents to maintain postural stability during performance of secondary tasks
 - Exercise Level 1: Have no dual tasks
 - Exercise level 2: has a motor task (bouncing a ball) added to the basic exercise such as an agility course
 - Exercise level 3: has a cognitive task (performing math or memory problems) added to the same basic exercise
 - The progression of adding secondary tasks to gait and balance tasks serves as a training device as well as a tool to help residents understand the relationship between safe mobility and secondary tasks in everyday life



- **Exercises for specific conditions/concerns**

- **Cognitive Task and Balance Task Example - One Foot and One Toe Behind**

- Stand behind your chair and hold on to it
- Place your right foot flat on the ground and bring your left foot behind your right but as you set it down only allow the big toe to touch the ground
- Most of your weight should be on your right foot
- Balance there for 30 seconds and try to use your chair as little as possible
- To make it harder, you can move your head up and down
- Look up at the ceiling and then slowly move you head down and look at the floor and repeat for 30 seconds (do not strain to far back just enough to see the ceiling or too far forward just enough to see the floor)



- **Exercises for specific conditions/concerns**

- **Cognitive Task and Walking Task Example**

- **Basic** – Walk forward taking normal-length steps, but bring your knees up higher than usual with every step. The higher you raise your knees that is comfortable for you, the harder it will be
- **Intermediate** – Walk forward again, but this time, only raise your left knee as you walk. Your right leg should just take a normal-looking step forward without exaggerated knee lift. Try again with the opposite leg
- **Advanced** – This time you will walk forward and take a high knee with every third step – Quite tricky!!



- **Exercises for specific conditions/concerns**
 - **More Advanced Cognitive Impairments**
 - **Can participate if**
 - **They can follow simple commands and/or**
 - **They can mimic movements**





- **Involving the team:**

- **Can be done during activities**

- Treasure hunts
 - Obstacle courses
 - Video exercise games
 - Throwing a ball
 - Tai Chi
 - Yoga
 - Dancing
 - Walking Courses
 - Do activities while standing (i.e, cooking or arts and crafts)

- **Offer programs during the day and evening**



- **Input on the program from residents and family members**





• Restorative & Mobility Programs

• Restorative Nursing Program-MDS Requirements

- Technique, training or skill practice was performed for a total of at least 15 minutes per 24 hours
- The 15 minutes can be broken up (i.e. remove & clean splint and skin, inspect skin and perform ROM for a total of 5 minutes 3x/day)
- Need 2 or more 15 minute restorative programs for 6-7 days/week
- Restorative nursing does not include groups with more than four residents per supervising helper or caregiver.





• Coordination of the Program:

- Physician must approve and order the exercise program
- Therapy to do the initial assessment and setting up of the individual resident's program for Nursing/Designee
- Therapy to competency test Nursing/Designee implementing the individual resident's program
- Dietary to ensure proper calories and protein intake for level of exercises
- Nursing to refer back to Therapy when a resident needs adjustment of the program (i.e. decline, plateau, need for more aggressive exercises, pain or change in ability to perform exercises)





• Restorative & Mobility Programs

• Restorative Nursing Program-MDS Requirements

- H0200C, H0500 **Urinary toileting program and/or bowel toileting program
- O0500A,B **Passive and/or active ROM
- O0500C Splint or brace assistance
- O0500D,F **Bed mobility and/or walking training
- O0500E Transfer training
- O0500G Dressing and/or grooming training
- O0500H Eating and/or swallowing training
- O0500I Amputation/prostheses care
- O0500J Communication training

****Count as one service even if both provided**



• Restorative & Mobility Programs

- Restorative Nursing Program-MDS Requirements
O0500B, Range of Motion (Active) Code
exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.



• Restorative & Mobility Programs

• Restorative Nursing Program-MDS

Requirements – Example of 2 programs

- Active ROM exercises AND Walking
- Active ROM exercises AND Transfers
- Active ROM exercises AND Bed mobility
- Active ROM exercises AND Bladder program
- Active ROM exercises AND Splint or Brace assistance
- Active ROM exercises AND Dressing and Grooming Training, etc.



• Restorative & Mobility Programs

- Restorative Nursing Program

- Skilled Care-Medicare A

- Rehabilitation nursing: 2 activities, 15 minutes each per day for 6-7 days per week.
 - Must be in conjunction with therapy, 45 minutes, 3 days per week





• Restorative & Mobility Programs

- Restorative Nursing Program

- Restorative Nursing Programs

- Therapy set up functional maintenance and do periodic updates (Part B)
 - Restorative Nursing provides the activities





• Restorative & Mobility Programs

- Restorative Nursing Program

- Restorative Nursing Programs – maintenance
 - Restorative Nursing provides the activities





• Restorative & Mobility Programs

• Restorative Nursing Program-MDS Requirements

- The care plan & medical record must document **measurable objectives and interventions**
- The medical record must reflect periodic evaluation by a licensed nurse.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity
- A registered nurse or licensed practical (vocational) nurse must supervise the activities in a restorative nursing program.





Individual Resident Goal Setting

- **Needed for Starting Point & to Measure Progress**
 - **Short Physical Performance Battery (SPPB)**
 - **Anthropometric Measurements**
 - **Muscle Quality Index**
 - **Hand Grip Strength**
 - **Steps per Day**
 - **Resting Heart Rate**
 - **Resting Blood Pressure**
 - **Waist to Hip Ratio**
 - **The Resident's Goal**



• Restorative & Mobility Programs

• Restorative Nursing Program-MDS Requirements

- If the resident does not meet MDS requirements for reimbursement, the program should still be implemented – Payment shouldn't drive the program
- Example: Resident can perform exercise program 3 days a week or can only perform one 15 minute program per day

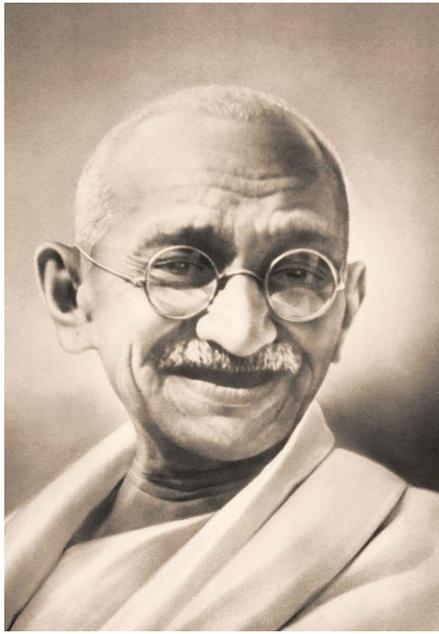




- **Overall End Goal**

- Keep residents active during the day
- Promote sleep at night





~ Mahatma Gandhi
“How to initiate change.”

“First they ignore you,
Then they laugh at you,
Then they attack you,
Then you win.”



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**Senior
Providers**
RESOURCE, LLC



Thanks for your participation!!!

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**Protecting and Defending your
Professional License**

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Part I:

**THINGS YOU SHOULD KNOW
TO PROTECT YOUR LICENSE**



There are a number of itemized reasons for disciplining a health care professional and nurses in particular as well as a number of things that are implied

- 
- Some you may not know:
 - Failing to report a fellow professional (nurse or otherwise) that you know violated their act
 - Failing to pay federally guaranteed school loans

- 
- Misleading, deceptive or fraudulent representation in the practice of nursing
 - Violating Board rules – do you even know the Board rules?

- 
- Failure to take educational courses required by your license
 - Discipline in another state that would be grounds for discipline in Florida

- 
- Failing to report that you have been disciplined or convicted of a crime
 - Aiding someone in practicing without a license

- 
- File a false response to a request or required document or failing to file one at all
 - Practice beyond your scope of practice

- 
- Delegating to someone who is not qualified by training, experience or license
 - Sexual misconduct

- 
- Using information that you have on a person who was in a motor vehicle accident for personal gain or solicitation
 - Being unable to practice because of illness or use of alcohol, drugs, narcotics or chemicals

- 
- Testing positive for certain drugs which are either illegal or used illegally (without a prescription or health reason) during workplace screening

- 
- Preparing a patient for a wrong-site or wrong procedure
 - Medicaid fraud
 - Being excluded from Medicare or Medicaid
 - Health care fraud

Sexual misconduct:

- Using the nurse-patient relationship to attempt to or induce a patient to engage in sexual activity outside the scope of generally accepted examination or treatment (F.S. 464.017)

Unprofessional conduct:

- Inaccurate recording
- Misappropriating drugs, supplies or equipment
- Leaving a nursing assignment without advising licensed nursing personnel
- Stealing from a patient

- 
- Violating the integrity of a medication administration system or information technology system
 - Falsifying or altering of patient records or nursing progress notes, employment applications or time records

- 
- Violating confidentiality of information or knowledge concerning a patient
 - Discriminating on the basis of race, creed, religion, sex, age or national origin in the rendering of nursing services

- 
- Engaging in fraud, misrepresentation or deceit in taking the licensing exam

- 
- Impersonating another licensed practitioner or allowing someone to use your certificate to practice nursing

- 
- Providing incorrect information to an employer regarding the status of your license
 - Practicing beyond the scope of your license, education or experience

- 
- Using force against a patient, striking a patient or throwing objects at a patient
 - Using abusive, threatening or foul language in front of a patient or directing such language toward a patient

UNPAID SCHOOL LOANS:

- If you have unpaid school loans or service scholarship obligations which are behind in payments you may have your license revoked or suspended:
- Must be federally guaranteed

- 
- Department will, at a minimum, suspend your license until payment terms are agreed upon or obligation resumed.

- 
- When suspension ends, the licensee shall be on probation until the obligation is paid
 - 10% fine on defaulted loan amount

MEDICAID AND MEDICARE ISSUES:

- Fraud in recording information for payment by either program
- On the exclusionary list for either program

Guilty of accepting or soliciting kickbacks (state)

- A remuneration or payment, by or on behalf of a provider of health care services or items, to any person as an incentive or inducement to refer patients for



past or future services or items,
when the payment is not tax
deductible as an ordinary and
necessary expense

- 
- May be indirect or direct
 - Overtly or covertly
 - Cash or kind

F.S. 456.054

Also similar federal law

Some acts considered minor:

- Some acts considered minor:
- False or misleading advertising with no criminal prosecution

- 
- Issuance of a worthless check to the Department or your Board when person does not practice on an inactive license

- 
- Failure to report address change
 - Improper use of nursing title
provided no practice issues involved

Others are felonies:

- Practicing without a license
- Using or attempting to employ unlicensed persons in the practice of nursing

- 
- Using misleading statements or knowingly misrepresenting to get a license or certificate



Part II:
INVESTIGATION AND
PROSECUTION

OOPS! You have gotten an
investigative letter. What do you
now do to protect your license?



You will be given an opportunity to respond within 20 days. While the 20 day limitation is statutory, we have never had an occasion where the investigator or attorney assigned to the case did not permit us to file more information after that date



A letter to you is the trigger for you to respond. Often the letters permit a meeting with the investigator. Such a meeting is not recommended



If you are going to hire an attorney this is the best time to do it. By getting an attorney at this stage you may save a lot of expense and heartache down the road



A written response with appropriate attachments is usually best



The investigative letter will have a
copy of the complaint filed against
you attached



Usually complainant identified but
on occasion may be anonymous



Respond only to the allegations in the complaint – that is all you are being investigated for at this time but you can open up more issues if you send too much information in the letter



Include statements from others,
pictures or exhibits with your letter,
as appropriate



This is the best time to get your side
of the story told



The investigator may contact you or your attorney for more information. Respond in writing. Not recommended you have conversation with the investigator



The investigator will likely contact the facility where the incident occurred and/or where you work for more information



The attorney will collect all data
he/she thinks relevant and prepare
a synopsis



Each Board has one or more prosecuting attorneys who will then review the material and make a recommendation to the probable cause panel of your Board



That recommendation holds a lot of
weight with the panels



The attorney will advise the probable cause panel as to whether there appears to be sufficient evidence to pursue an action against the licensee



The Board of Nursing has 2 panels of 3 persons each appointed by the Chair of the Board. If workload demands a third panel can be appointed by the Chair. A majority vote determines whether a charge is brought



Members of the Probable Cause Panel will not be allowed to vote on ultimate disposition of the matter by settlement or hearing decision



If for some reason – for example,
new information comes to light –
the same probable cause panel may
reconsider their determination



Panel recommends penalties for
settlement purposes based on:

Material submitted to them for
review

Board's past treatment of similar
cases

Board's disciplinary guidelines



If probable cause is found, a
Complaint will be prepared and
served on the licensee



This is the start of the process to
seek review or settle the matter



The deadlines in the Complaint are jurisdictional and must be complied with even if settlement is ongoing



10 days after probable cause is found,
the file becomes public record.

If no probable cause is found the file
remains sealed and eventually
destroyed



If you do not answer the Complaint, you are, in essence admitting the allegations and at the mercy of the Board. This is never a good place to be



You will receive an election of remedies with the Complaint. If you check that you are admitting the facts, they can be used against you. This is a very critical time to contact an attorney



If you ask for an informal hearing you will go before the Board and argue mitigating reasons why you should not be disciplined or the discipline recommended in the Complaint is too harsh



If you ask for a formal hearing:

- You must file a Petition in accordance with the Administrative Procedures Act alleging at least on issue of material fact

- 
- Your case will be forwarded to the Division of Administrative Hearings and assigned to an administrative law judge who is not affiliated with the Board

- 
- You have the right to discovery, depositions, a hearing and an opportunity to present a synopsis of the testimony and exhibits and legal argument in writing after the hearing

- 
- The judge will issue a recommended order to the Board, setting out his findings of fact and conclusions of law

- 
- The recommended order goes to the Board which can only overturn findings of fact if the record does not substantially support the finding. The Board can overturn conclusions of law the Board finds erroneous.

- “ The determination of whether or not a licensee has violated the laws and rules regulating the profession, including a determination of the reasonable standard of care, is a conclusion of law to be determined by the Board... and not a determination of fact...” F.S. 456.073 (5)



Both attorneys can file exceptions to the Administrative Law Judge's findings which go to the Board with the Judge's Recommended Order



Settlement discussions can occur at any time within this process

Settlements must be approved by the Board

If the Board rejects your Settlement you may go back to negotiations. The Board cannot rewrite the Settlement without your agreement



Decisions can be appealed to the
District Court of Appeal



Disciplinary Guidelines for the
most common offenses are found
in Rule 64B9-8.006

Thank you for Participating

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Match.com

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Match.com Profile

- Gender
- Age
- Profession
- Favorite color
- Favorite song
- Favorite thing to do





Yesterday's LTC Match.com

- All about census
- Matches were with
 - Hospitals
 - Discharge planners
 - Case management
 - Social services
 - Doctors

Tomorrow's Match.com

- Partners
- Census

Partners

- ACOs
 - Finding more savings
 - And more savings after that
- Health Systems
 - Bundled Payments
 - Follow the money
- Health Care Plans
 - Medicare replacement plans
 - Medicaid managed care

1st Date, 2nd Date or No Date at all

- Taking the lead
 - Who's in charge
 - What's the goal
 - How to get there
- Becoming a couple
 - You are being watched
 - And measured
 - Compatible
 - Commitment

Affordable Care Act

- Authorizes CMS with broad authority
 - Test new payment models
 - Moving away from Fee for Service
 - ACOs
 - Episodes of care
 - Bundled payment
 - Emphasis on quality of care
 - Outcomes
 - Cost

Accountable Care Organizations

- All about savings
- Bench marks
 - Financial
 - Quality
- Out patient
- Hospital
- Savings ratcheting down
- Now Long Term Care

Systems and Plans

- Bundled Payments
 - Bundled Payments for Care Improvement, BPCI.
- Valued Based Purchasing
 - Focus on SNF and NF
 - Metrix, satisfaction, public reporting
- Global Capitation
 - A set dollar amount for one person for one episode

Bundled Payments in LTC

- Model 1
 - Payments to hospitals. Ends December 2016
- Model 2
 - Payments to hospitals and LTC up to 90 days.
- Model 3
 - Triggered by hospital stay. Payments are to LTC.*
- Model 4
 - Hospital stay. One payment to all partners.

Match.com

- Picking the right partner
 - A win-win relationship
- Aligning goals and purpose
 - Achievable quality and cost goals
- Staying in the dating game
 - Narrowing networks

Bringing Up Past Dating Won't Help

- Loyalty
- Local
- Choice

Partnership

- What can you do for me?
- What can we do together?

SWOT Thoughts

- Strengths
 - Measurements matter
 - Size matters
- Weaknesses
 - Size matters
- Opportunities
 - Business focus from census to partnerships
 - Mergers and acquisitions
- Threats
 - Not looking forward

Match.com

- My favorite color is blue
- My favorite thing to do is being with FADONA

Thank you



References

- Match.com
- *Health Policy Brief*, Robert Wood Johnson Foundation, November 23, 2015
- U.S. Dept. of Health and Human Services, Report to Congress: Plan to Implement a Medicare Skilled Nursing Facility Value-Based Purchasing Program.



RESIDENT CENTERED CARE PLANS FOR SUCCESS!

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RAI REFRESHER

RAI Definition

The resident assessment instrument (RAI) is a process developed to assist the facility staff to look at Residents in a holistic manner, as individuals whom quality of life and care are both important.

Why we Meet?

Individuals typically get admitted to a skilled nursing facility (SNF) due to functional status problems caused by physical and cognitive decline.

However, we are not defined by our medical problems but by who we are...

What is the RAI?

So then, the RAI is a problem identification process which consists of assessment, decision making, planning, implementation and evaluation components.

Sounds a lot like risk management to me

Steps to Assess?

Assessment:

This is to make observations, gather data, and knowledge about the Resident.

Decision Making Step

To establish the 'whats' and 'whys' of a problem, decision making is instrumental.

Care Planning Expectations

To establish a course or direction for action in support of moving a Resident towards a specific goal, care plans are crafted to direct the “how” of Resident care.

Evaluation?

How did it go?

To critically review care plans, goals, and interventions and implementing revisions, assists in continuous quality improvement.

Respond to Individualized Care

Why do Residents respond?

Why not, care consideration of individual problems and causes, linked with specific approaches to care decrease deterioration and increase quality of care and life~

Communication

Communication is the first step in assessment and in clinical risk management.

The RAI process supports communication between Staff, Resident's, and Family

Involvement Increases



Through the RAI process Resident and Family involvement which can promote partnership in care and in risk.

With input provided by all on goals and the methods to achieve them, everyone is then vested.

The MDS

The MDS is a core set of screening, clinical, and function elements that have common definitions and coding categories.

Chapter 3 the Item-by-Item review is exceptional as a means to create common terms and set the stage for appropriate assessment that leads to quality care plans.

Care Area Triggers

The value of a Care Area Trigger is that the response from the MDS advises you of a need for further investigation.

There are 20 Care Area Triggers~

Care Area Assessments

The Care Area Assessment is an important aspect of the RAI

As there are 20 Care Area Triggers, there are 20 Care Area Assessments which correspond.

Thus a 2 on the MDS would match with CAA 2 which is Cognition.

Purpose of the CAA

The Purpose of a CAA is three fold:

- Collect more data on the topic,
- Analyze the data collected, and
- Come to a decision.

CAA Decision

[] Proceed or [] Not Proceed

To a plan of care, is the decision the assessor should clearly make.

Interdisciplinary

It is not stated or required who or what discipline should do which sections of the RAI or Care Plan.

However, it is expected that your team includes varied clinical expertise for a holistic view.

This means nursing alone should **not** do complete the process.

Part of Daily Life

While certain aspects of the process are dictated by regulation not all parts are.

The process was not intended to be a facility burden and facilities are encouraged by CMS to be creative.

Being Creative

Being creative means bring the process into the facility day to day life, not just done by the one person or the IDT.

Those providing the care and services have much more knowledge of the Resident than IDT members typically do.

Timing

The plan of care is due on or before the 7th day after the comprehensive RAI is completed.

So it could be the 21st day for the care plan but that depends on when the RAI itself was completed.

Then thereafter....

Significant Change

A SCSA is a decline or improvement in Resident's status that:

1. Will not normally resolve itself without intervention by staff or by using standard disease-related clinical interventions “not self limiting”.

SCSA and...or...

2. Impacts more than one area of the Residents health care status, and or
3. Requires interdisciplinary review or revision of the **plan of care**.

Self Limiting

Self Limiting is when a condition will normally resolve without intervention or staff participation related to the change.

For example a 5% weight loss after new dentures which reverses itself within 14 days may be considered self limiting.

Impacts...

A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement.

Having said that this does not mean that one important decline might not require SCSA due to not being self limiting....

Care Plan Revision

This is a tricky one, as changing or revising a plan of care in it of itself does not require a SCSA and should not be discouraged.

A significant revision is really the intention where a new or more extensive approach or disease –related clinical intervention is required.

Terminal Condition

Mandatory SCSA for Residents using Hospice services but a choice for Residents who are declared terminal.

What is the purpose of this and how does it impact the plan of care?

Terminal Residents

If the Resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment would be required.

Choices in Process

There are choices in the process in working with Residents who have terminal illnesses.

Clearly the importance of documentation of anticipated negative outcome is critical in his area.

IDT should do SCSA when:

The Resident is newly diagnosed with end-stage disease when:

- A change is reflected in more than one area of decline; and
- The Resident's status will not normally resolve itself; and
- The Resident's Status requires interdisciplinary review or revision of the care plan.

Planning the Care

We do this entire process to develop a plan to provide care and services for the Residents.

The manual stresses linkage throughout it's pages, lets discuss this...

Care Planning

The process of care planning is one of looking at a Resident as a whole, human being, an individual, that may have similarities to others around them but are also unique.

Care Planning

Care Planning can best be described as a process that has several steps that may occur at the same time or in a sequence.

Care Planning

They include:

- individual and team assessment,
- collection of data to analyze individual strengths and weaknesses,
- Resident participation via interest or ability, and
- Family participation via interest or ability.

Problem Statement

The care plan problem statement should be clear and Resident focused. There are many good ways to word your care plans.

Care Plan Considerations

The resident is at risk for ?....

which has resulted in ?....

Creating ?

Complicated by?....

Resulting in the risk of ?....

Etc.

Problem Statements

An Example:

Resident presents with a 2.0 cm x 1.5 cm Stage II pressure ulcer with superficial depth and no drainage or odor on admission from hospital.

Goals

Goals should be understandable, clear, relate to the problem statement, and be measurable.

There should be no mystery in the goal statement.

Goal Considerations

The Resident will ?....as evidenced by
?.... on or before ?

Be sure to say, what will happen, when,
and how will you know it?

Goal Example

The Pressure Ulcer will resolve without complication as evidenced by observation during daily care and documentation post care on or before....the review date stated

Goals

Should advise what will happen and how you will know it.

The Resident will...as evidenced by...on or before the review date....

Goals

Goals should NOT be part of the daily aspects of care such as 'call bell in place', praise all attempts, encourage to accept fluids, and so forth.

They are specific approaches designed to help the resident reach the goals, etc.

Goal Considerations

The Resident will ?...as evidenced by ?

....

on or before ?

What is expected to occur, how will it be known, and when will that happen?

Approaches

The approaches are important steps that are taken to support achievement of the goal to resolve the problem or support the identified need or concern.

Approaches

Approaches are specific to the goal to help resolve, abate, or minimize a problem, or to maintain a strength.

They should NOT be generic such as call bell in place or diet as ordered, etc.

Summary

The Director of Nursing role includes the establishment and development the clinical quality of care. This includes oversight of the Resident Assessment Instrument and program at your facility.

THANK YOU



We thank you for your time today.

To learn more about this or to discuss services please contact Robin A. Bleier at robin@rbhealthpartners.com or visit our web at www.rbhealthpartners.com