The Nursing Department Based on Professional and Regulatory Standards

Session II
Day 2

Objectives

- Utilize a nurse practice act decision tree to respond to nurse practice violations
- Display an understanding of litigation issues in the nursing home
- Apply procedures to limit medication errors
- Demonstrate an understanding of how unnecessary rehospitalizations impact health care

What Every DON Needs to Know

The Nurse Practice Act

- All nurses share a common foundation of responsibility and accountability that is outlined by the practice of nursing and consistent with their level of licensure.
- The nurse’s scope of practice or set of knowledge and skills are derived from the legal authority in Wisconsin Chapter 441, commonly referred to as the Nurse Practice Act.

The Nurse Practice Act

- The Nurse Practice Act – 2 subchapters
  #1 - Regulation of Nursing defines the basic statutory responsibilities, requirement for the examination and licensure of nurses and authority of the board of nursing for disciplinary action.
  #2 - Nurse Licensure Compact sets practice privileges of nurses licensed in other states.

The Nurse Practice Act

- Administrative Code relating to nursing in WI
  http://www.legis.state.wi.us/rsb/code/n/n006.pdf

- Statutes relating to Nursing in State of WI
  http://www.legis.state.wi.us/statutes/99Stat0441.pdf

- Links to administrative code for WI that involves Nursing. (You must choose "N", and you will be sent to the right place)
  http://www.drl.state.wi.us/Regulation/publications/admincode_statutes.htm
The Nurse Practice Act

- The scope of practice of nurses is further defined by the Wisconsin Administrative Code, N6, Standards of Practice of the Registered Nurse and Licensed Practical Nurse.
- The code defines the minimum practice standards for registered nurses and licensed practical nurses.

The RN and the Nurse Practice Act

RN’s use the nursing process including assessment, planning, intervention and evaluation, in providing nursing care.
- Delegation of a nursing task involves assessment of the knowledge and skill level of those supervised, providing direction, assistance, observation and monitoring of those supervised and evaluation of the outcome of the performed task.

The Nurse Practice Act

Read it
- Have your nurses read it
- Ask questions
- Review your policies

Litigation Survival Skills

Terms To Know
- **Negligence**: failure to act as a reasonably prudent person would act under the same circumstances --- failure to do something --- to do something carelessly or recklessly
- **Malpractice**: negligence by a professional

Litigation: Terms to Know

- **Assault**: a threat or attempt to inflict bodily harm combined with the ability to commit the act. i.e.: "If you move one more inch, I'll tie you to the bed."
- **Battery**: intentional harmful or offensive contact that occurs without consent (use of restraints without an order or a written policy of protocol).

Litigation: Terms to Know

- **Libel**: publication of defamatory (Synonym: slanderous, derogatory, etc.) statements
- Nurses Notes will be scrutinized for libel.
- **Slander**: oral defamatory statements (can be words or gestures)
Litigation: Terms to Know

Statute of Limitations:
- There are periods defined by state statute during which you may file a claim or it is forever barred.
- The clock starts at the time of the occurrence or at the time the occurrence was discovered or should have been discovered, such as a lap sponge left in a patient’s abdomen that was discovered several years post operatively.

Informed Consent:
- Permission given for a proposed treatment or procedure following full disclosure of risks, benefits, and alternatives by the physician --- when you are asked to sign your name as a witness on the consent form. Remember you are witnessing the patient’s signature only.

Litigation: Physician Orders

Physician Orders
- Telephone Orders: Repeat each order to verify what you heard is what was ordered.
- Illegible Orders: Ask the physician for the interpretation. NEVER GUESS!
- Inappropriate Orders: Inform the physician of the policy and standards. If the physician insists that the order be completed, contact the supervisor immediately.

Litigation: Communication is Key

Be honest.
- Don't be afraid to apologize if an apology is needed.
- Be a good listener. Sometimes it isn't what they say, but how they say it.
- A little PR goes a long way.
- Schedule time with each shift to speak with the residents and his family.

Schedule a care conference.
- The medical record is the ultimate communication tool.
- Remember, most lawsuits are filed simply because the patient or the family isn't happy. Good communication skills can alleviate this.
- Schedule time with each shift to speak with the residents and his family.

Litigation: Documentation

- Be accurate, objective, and complete.
- Beware - Many courts still feel that if you didn't chart it, you didn't do it.
- Use only approved abbreviations (found in the Policy and Procedure Manual).
- If you make an error, draw a line through it and write "mistake in entry" followed by your initials. Do not write "error" as it has a negative connotation.
**Litigation: Documentation**
- Document calls to physicians noting the time the page was made or the call was placed, as well as the time the call was returned and the physician’s response.
- Document all teaching. If family members are present, list their names in your note.
- Document the review of "discharge instructions" including the review of any medications prescribed and any handouts provided is of utmost importance.
- Document all patient comments regarding their condition, both the positive and negative ones.

**Standards of Practice**
- Use AMDA Guidelines and State Operations Manual in writing your facility policies and procedures.
- Physician Notification
  - Acute Change of Condition in the Long-Term Care Setting, Clinical Practice Guideline
  - American Medical Directors Association
  - http://www.amda.com/info/cpg/

**Standard of Care Resources**
- Protocols for Physician Notification: Assessing Patients and Collecting Data on Nursing Facility Patients
- A Guide for Nurses on Effective Communication with Physicians
  - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2757754/
- American Medical Directors Association
  - http://www.amda.com/info/cpg/

**Ensuring Standards of Practice**

**Admission and Discharge Planning**
- Need to focus on who we are admitting
- What are we doing to facilitate transition of care upon discharge
Preadmission Considerations

Preadmission Checklist
- Gathering/recording info from referring facility
- Onsite assessment
- Clinical assessment and medication review
- Identify “red flag” conditions and procedures, vulnerability for re-hospitalization, i.e., CHF, MI, pneumonia, high risk surgical procedures, sepsis/UTI, MDRO’s

Preadmission Considerations

- Identify high risk chronic diseases/conditions, i.e., cardiac dx, pneumonia, CHF, recurring UTIs, etc..
- Cost analysis r/t medications, treatments, equipment
- Determine appropriate Level of Care (LOC) (SNF, Home care, Hospice)
- Financial info, insurance representative, responsible party
- Advance Directives/Living Will

Admission Processes

Preadmission call
- Ensure someone is available to greet resident and family/responsible party immediately
- Introduce to room, roommate, facility, routine
- Inform of admission process
- Gather data from resident and family/responsible party
- Assist with belongings as needed

Admission Processes

- Admission Checklist
- Review data from admitting facility
- Review pre-admission assessment and info
- Clarify orders as needed, ensure DX for each medication

Admission Processes

- Comprehensive nursing admission assessment and data gathering within first 8 hours
- Nurse Manager/DON to review data collection upon completion
- Obtain baseline V.S., neuros, if edema-girth etc..

Admission Processes

- Medication Reconciliation
  - Check drug history to ensure all medications prior to hospitalization are accounted for
  - Are possible drug interactions? (e.g. Anticoagulants / NSAID or antibiotic?)
  - Encourage fluids with medications, unless contraindicated
Discharge Processes
- Begin discharge planning on admission
  ◦ Written in plan of care
  ◦ Communicated with resident/family/responsible party and staff
- Self-Administration of Medication
- Identify resident learning barriers
- Resident Education Modules
- Discharge Interviews and Check In on Status

Change in Condition
- Head-to-toe baseline assessment on Admit
- Head-to-toe reassessment & VS with any suspicion of change in condition. Observe for subtle changes. (i.e., weight edema)
- Notify family/responsible party, MD and RN of any change in condition; other changes to Care Plan
- Document

Documentation & Communication
- Acute illness and/or re-hospitalization vulnerability
  ◦ Temporary care plan upon admission
  ◦ High risk care plan
  ◦ Follow up charting log
  ◦ Guidelines, specific for DX or condition
    ◦ Care Paths/Care plans
    ◦ Assessments

Care Planning
- Nursing care plans for long term care are blueprints for residents’ entire care needs, and direct the actions of all health care team members. Written nursing care plans for long term care are usually arranged into the three parts of Care Plan Problem, Care Plan Goal, and Care Plan Interventions.

  - Nursing care plan problem statements are traditionally based on a nursing diagnosis.

Communication is Key!
Communication with:
- MD/NP
- Pharmacists
- RD
- Entire IDT
- What are your facility goals?

Change in Condition
- Involve all staff to be alert for resident changes
- Nurse Aide “Stop and Watch” early warning tool (Interact II)
- Subtle changes like shoes too tight. Consider edema
Care Plan - Problem Statement

- Nursing care plan problem statements are traditionally based on a nursing diagnosis. The nursing diagnosis is a problem that nurses can identify and treat. Medical diagnoses can be part of the nursing care plan problem statement, but not the actual problem itself. The most commonly used nursing diagnoses are the ones approved by NANDA, the North American Nursing Diagnosis Association, and are grouped by functional health patterns.

Care Plan - Goals

- The nursing care plan goal can be to prevent a potential problem from occurring, to maintain a present status or level of functional ability, or to resolve it.

- The goals of nursing care need to be specific, measurable, appropriate, and realistic.

Care Plan - Interventions

- Nursing care plan interventions describe specific actions taken by the staff to achieve the stated goal.

- Interventions are worded in terms of what the staff will do to assist the resident to meet the stated goals for the problem.

Care Plan - Evaluation

- Evaluation of nursing care plans for long term care is an ongoing activity that examines the problem itself, the goals, and the interventions to determine if they are still applicable or if changes to the care plan need to be made.

Care Plans and the IDT

- Care plans must be interdisciplinary. Nursing cannot write entire care plan.

- Must be reviewed at a minimum quarterly at care conference.

- Review with Resident and Family/Responsible Party.

- Include medications at monitoring.

- Add strengths to care.

Patient/Resident Centered Care

- The "culture change" movement represents a fundamental shift in thinking about nursing homes.

- Facilities are viewed not as health care institutions, but as person-centered homes offering long-term care services.

- Culture-change principles and practices have been shaped by shared concerns among consumers, policy-makers, and providers regarding the value and quality of care offered in traditional nursing homes.
Patient/Resident Centered Care

- Patient centered care has shown promise in improving quality of life, as well as quality of care,
- Assisting with such problems as high staff turnover.
- Policy-makers need to encourage culture change and capitalize on its transformational power through regulation, reimbursement, public reporting and other mechanisms.

Patient Centered Care - Where to Start

- Train on leadership skills
- Train staff on concepts/preferences
- Establish task force
- Have staff (Nurses, nurse aides, SS) interview for resident preferences (When do they like to wake-up, go to bed, when brush teeth, eat meals, activities, etc.)

Patient Centered Care

- Have history of resident (what their occupation was, how many children, where they lived, etc.)
- Place history and preference where staff can easily access while providing cares
- Work with task force to review meal times and review choices for starting a wake at will program
- Start wake at will program and adjust staff schedules accordingly

Staff Education

Creation & Presentation of In-Services

Adult Learning Principles

Learning Domains
- Cognitive domain
- Psychomotor domain
- Affective domain

Principles of Adult Learning

- Create a safe, supportive environment
- Make learning relevant to experience and future work.
- Include all three learning domains
  - Knowledge
  - Attitudes
  - Skills
- Create ways to practice this knowledge
- Recognize and appeal to varied learning styles
How do we take in information

- Three Main Sensory Receivers
  - Vision
  - Listening
  - Touch
- One receives is usually dominant
  - 40% are visual learners
  - 40% are kinesthetic learners
  - 20% are auditory learners

Visual learners

- Prefer written material.
- Uses highlighter and sticky notes
- Likes tools like flash cards to learn new information

Teaching Strategies
- Use visual aids - charts
- Provide information on outlines and handouts
- Record discussions using flip charts

Auditory Learners

- Prefer verbal to written instruction
- Learn through story telling
- Likes interaction and group discussions
- May move lips, read aloud and talk to themselves

Teaching Strategies
- Tell them what you are going to tell them.
- Lecture and discussions.

Kinesthetic Learners

- Hands-on, active experiences.
- Difficulty sitting/squirm/fidget
- May doodle or play with objects
- Don’t like to read instructions

Teaching Strategies
- Teaching strategies
- Games, role plays
- Practical exercises
- Return demonstrations
- Written assignments

Cognitive Domain

The learner is knowledge based

Instructional levels
- Fact
- Understanding
- Application

Cognitive Domain

To teach, use lectures, presentation and written materials.

To test retention, use both objective and subjective test items
Psychomotor Domain

- Skill-based: The nurse will produce a “product of their skills at the bedside.
- Instructional level:
  a) Imitation
  b) Practice
  c) Habit

Psychomotor Domain

To teach—use demonstration
- To test-use performance skill testing
- For example demonstration technique and a return demonstration.

Affective Domain

- To teach, hold discussions
- To test, observe interactions of the new employee with the residents.

Affective Domain

- Adults prefer self-direction in learning
- Life experiences are a rich resource for learning
- Readiness to learn is based on real-life relevance to problem-solving: “need to know”
- Learning is valued for its application; to gain competencies that matter in the learners daily life.

Principles of Adult Learning

- Adult learning is a self activity
- Adult learning is intentional
- Adult learning is an interactive process
- Adult learning is a unified process
- Adult learning is influenced by motivation
- Adult learning is influenced by the readiness of the learner.

Principles of Adult Learning

- Adult learning is influenced by the learning environment.
- Adult learning is most effective when it is organized and clearly communicated.
- Adult learning is built on past knowledge
- Adult learning is facilitated by positive and immediate feedback.
Creation & Presentation of In-Services

Nursing Education Program

Purpose:
- Keep improving nursing staff skills
- Provide regular updates on Policy & Procedure
- Provide information on regulatory compliance
- Present valuable information on patient care
- Establish expectations for performance

Educational Needs Assessment

Question staff on a yearly basis to encourage staff participation in planning educational calendar.

- What time could you attend the educational program? (list proposed times on the assessment)
- Preferred length of the educational program?
- Where would you like to attend, work area, onsite-off site?
- What programs would you like to see on calendar?

Staff Education-Orientation/Annual

- OSHA: Safety, Blood Borne Pathogens
- Employee Right to Know
- HIPPA: Confidentiality of Medical Information
- Facility Policies
- Emergency Procedures
- Fire Prevention
- Resident Rights

Staff Education-Orientation/Annual

- Resident Protection and Abuse Reporting
- Rehabilitation Therapy
- Lifting and Transferring & Use of Lifts
- Oral Hygiene
- Programs For Developmentally Disabled Residents (If Facility admits)
- Approved Medical Abbreviations

Staff Education-Orientation/Annual

Infection Control/TB Plan

Programs to develop and improve Skill with respect to needs of the residents. Suggested Programs:
- Skin Care
- Activities of Daily Living
- Nutrition, Hydration
- Behavior Management
- Memory/Dementia Care
- Bowel and Bladder
- Change of Condition
- Accident Prevention

Staff Education- Nurses

Demonstration with return demonstration
- Geriatric head-to-toe assessment skills
- Clinical Systems Evaluation
- Critical Thinking
- IV’s,
- Critical labs
- Phlebotomy

Acute change in condition assessment
Documentation and reporting
### Creation & Presentation of In-Services

- Nursing Education Program: Methods of Delivery
  - Formal presentation – Power Point with handouts
  - Computerized learning – Care2Learn, Silver Chair
  - Written self study units – Memos, Topic Bulletins
  - Small group direct education – Wandering Instructor
  - Newsletters
  - Paycheck inserts
  - Role Plays

### Explore Education Alternatives

- Develop a yearly skills fair for your nursing staff to include proficiency check lists.
- Invite vendors in to assist with the skills fair.
- Develop story boards that can be placed in areas that are visible.
- Webinars
- You-Tube (Has some good educational programs)

### Creative Teaching Strategies

- Ice breakers
- Games
  - a) Trivial Pursuit
  - b) Who wants to be a millionaire
  - c) Jeopardy (infection control)
  - d) Wheel of fortune (any game)
  - e) Price is right (cost of staff supplies)

### Education- Record Keeping

- Ensure all educational offerings are documented for each staff member
- Keep a record of all nursing meeting attendance and topics of discussion
- Track CNA’s to ensure 12 hours/year

### Medication Management

- A drug safety study completed by the Institute of Medicine (IOM) found that medication errors are surprisingly common; approximately 800,000 preventable adverse drug events (ADE) occur each year in long-term care facilities.

- $887 million is spent annually to treat medication errors that occur in Medicare recipients ages 65 and older.

- American Journal of Medicine indicated that one out of every 10 nursing home residents suffers a medication-related injury
- 73 percent of the most severe injuries, including internal bleeding and death, was preventable
- Lawsuits involving drug errors made by nurses are also on the rise
Managing Medications - Errors

- Prescription of meds based on incomplete patient information such as not knowing allergies, other meds, previous diagnoses, and lab results.
- Miscommunication of drug orders, which can involve:
  - Poor handwriting,
  - Confusion between drugs with similar names,
  - Misuse of zeroes and decimal points, confusion of metric and other dosing units
  - Inappropriate abbreviations.

Steps to Avoid Med Errors

Nurse is responsible for the review and transcription of a physician’s orders must be thorough, reliable, and diligent in analysis and clarification.
- Having knowledge of a medication’s safe dosage limits, potential side effects, toxicity, and indications and contraindications for use are important to the task.
- Have a current drug handbook available

Steps to Avoid Med Errors

- Illegible, unclear, or confusing medication orders must be clarified and the physician must be notified when communication is questionable or a discrepancy is identified.
- The organization’s standard abbreviation list should be used consistently by all nurses.
- Joint Commission has issued a “Do Not Use” list of abbreviations that are commonly misinterpreted. (http://www.jointcommission.org/PatientSafety/DoNotUseList/)

The 6 Rights of Med Administration

Ensure your staff are following the safe medication administration with the “six rights”:
1. The right drug
2. To the right resident
3. At the right time
4. The right dose
5. By the right route, and
6. With the right documentation

Medication Errors

- Never Assume

Medication Errors

- Residents have the right to receive accurate, timely, and easily understood information
- Providers have an obligation to inform residents and their responsible parties regarding the outcomes of care, treatment and services that have been provided, including medication errors.
Medication Errors

- Notify MD, resident/representative, charge RN of medication error.
- Monitor VS frequently and observe for changes in condition.
- Document what the resident received, the VS, and any change in resident status from baseline.
- DON may remove from med pass, perform competencies on all those who pass meds
- Consider a double check for Narc, Insulin, etc..

Medication Administration Tips

- Labels cannot be tampered with
- Do not ever mix medications (Pour the few left into the new bottle)
- Use direction change sticker for change in direction
- Consider 2 nurses to verify insulin
- Nurse to administer/verify Coumadin dose
- Always date bottle, eye drops, etc.. When opened.
- Train in orientation and perform med pass audits

Med Administration- Enteral Tubes

- Focus of National Patient Safety- 2007 33 patient safety issues, 4 near misses and 3 deaths
- Review policies and procedures
- Know difference between Gtube- Stomach and J-Tube Small Intestine. (Some meds only absorbed in stomach)
- Feeding tube placement must be checked prior
- Do not mix medications before or after

Med Administration-Enteral Tubes

- Provide 30cc of water after each medication
- Watch for do not crush medications being used
- Some medications have a time frame of not to be given within with feeding (e.g. Dilantin)
- Medications should be reviewed regularly and their possible interactions
- Some medications are likely to cause a blockage if not prepared, administered and flushed appropriately. (i.e, granular content of capsules such as omeprazole can cause blockages when wet.)

Medication Reconciliation

- Drug use in the older adult is disproportionately high
- People over 65 years of age consume 31% of the prescribed drugs secondary to:
  - Increased severity of chronic illness
  - Presence of multiple pathologies
  - Excessive prescribing
  - Multiple prescribers

Medication Reconciliation

Definition: The process of comparing a resident medications orders to all medications that the resident has been taking
- Medication Reconciliation will avoid
  - Omissions
  - Duplications
  - Dosing Errors
  - Drug Interactions
Medication Reconciliation

Five Step Process
- Develop a list of medications
- Develop a list of medications to be prescribed
- Compare the two lists
- Make clinical decisions based on the comparison
- Communicate the rectified list the care giver

Evidence of Poly-medicine
- Medications with no apparent indication
- Use of duplicate medications
- Use of interacting drugs
- Drugs contraindicated in concurrent conditions
- Inappropriate dosages
- Pharmacotherapy of adverse drug reactions.

Risks of Poly-medicine
- Hospitalizations- 25% of admissions may be drug related
- Decrease in physical function
- Impaired cognitive function
- Increased risk of falls

Specific Challenges in the Older Adult
Adverse Events
- 25% percent of the Medicare population have
- Five or more chronic diseases
- See 14 different physicians a year
- Fill 50 prescriptions a year
- Account for 2/3 of total Medicare spending
- 7000 deaths are attributed to medication errors
- Indications are that most medication related problems are predictable and preventable.
- Errors associated with preventable adverse drug reactions most often occur (56%) in prescribing and (61%) of the time in monitoring.
Specific Challenges in the Older Adult

- Residents with 9 or more medications have 2x greater odds of medication related problems than those with 9 or less medications.

- Drug related co-morbidities and mortality for the elderly exceeds $120 billion (this includes re-hospitalization costs)

Specific Challenges for the Older Adult

- Altered pharmacokinetics= action of drugs on the body
- Multiple co-morbidities
- Multiple drug therapies
- Poor adherence

Specific Challenges in the Older Adult

Absorption of Drugs
- Increased gastric PH
- Decreased absorptive surface area
- Decreased gastric mobility
- Delayed gastric emptying

Specific Challenges in the Older Adult

Distribution of Drugs
- Increased body fat
- Decreased lean muscle mass
- Decreased serum albumin
- Decreased cardiac output
- Decreased total body water

Specific Challenges in the Older Adult

Metabolism of Drugs
- Decreased hepatic blood flow
- Decreased hepatic mass
- Decreased activity of hepatic enzymes

Specific Challenges in the Older Adult

Excretion of Drugs
- Decreased renal blood flow
- Decreased glomerular filtration rate
- Decreased tubular secretion
- Decreased number of nephrons
Medication Effects on the Elderly

- Increased drug sensitivity
- Changes in the blood-brain barrier
- Alteration in the receptor properties
- Increased Adverse Drug Reactions

High Risk Medications

Avoid

- Long Acting Non-Steroidal Anti-Inflammatory Drugs (Indocin, Feldene)
- NSAIDS can increase risks of indigestion, bleeding in your stomach and colon. They may also affect your kidneys, blood pressure and make heart failure worse

High Risk Medications to Avoid

- Lanoxin in doses greater than 0.125 mg
  - Toxic to the older adults kidneys
- Diabetic drugs including Diabinese, Micronase, Diabeta
  - These medications can cause severe low blood sugar

High Risk Medications to Avoid

- Muscle relaxants including Flexeril, Robaxin, and Soma.
  - These medications will increase the risk for falls, constipation and problems urinating.
- Antianxiety and hypnotic medications including Sonata, Ambien, Valium, Xanax.
  - These medications will increase risk of falls and have a longer half-life.

High Risk Medications to Avoid

- Anticholinergic Drugs including Elavil, Tofranil, Artane, Ditropan
  - These medications may cause confusion, constipation, problems urinating, blurry vision and low blood pressure
- Antipsychotic medications including Haldol and Risperdal.
  - These medications can increase the risk of stroke, falls and death,

Medication Controlled Substances: Schedule 1

- Substances in this schedule have a high potential for abuse, have no currently accepted medical use in treatment in the United States, and there is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Some examples of substances listed in schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxyamphetamine (“ecstasy”).
Medication Controlled Substances: Schedule II

- Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.
  - Examples of single entity schedule II narcotics include morphine and opium. Other schedule II narcotic substances and their common name brand products include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®), and fentanyl (Sublimaze® or Duragesic®).
  - Examples of schedule II stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).

Medication Controlled Substances: Schedule III

- Substances in this schedule have a potential for abuse less than substances in schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.
  - Examples of schedule III narcotics include combination products containing less than 15 milligrams of hydrocodone per dosage unit (Vicodin®) and products containing not more than 90 milligrams of codeine per dosage unit (Tylemold with codeine®). Also included are buprenorphine products (Suboxone® and Subutex®) used to treat opioid addiction.

Medication Controlled Substances: Schedule IV

- Substances in this schedule have a low potential for abuse relative to substances in schedule III.
  - An example of a schedule IV narcotic is propoxyphene (Darvon® and Darvocet-N 100®).
  - Other schedule IV substances include: alprazolam (Xanax®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

Medication: Narcotic Count

- Recommend lock and count of controlled drugs I-IV
- Use bound books (Keep used ones for 5 years)
- Review policies and audit for correct narcotic count procedure
  - Use entry in front of book and go to page #
  - Nurse who is counting reads off the number and the second nurse verifies the correct count.
- Perform Narcotic Count Audits for procedure and for 2 signatures for each shift

Medication Diversion- Statistics

- 70% of drug users are employed (Fallon, 2001)
- Drug addiction costs organizations $81 billion in 2000 (Fallon, 2001)
- 10–20% of nurses have substance abuse issues (Griffith, 1999)
- Nurses tend to use certain prescription drugs instead of street drugs
- Hundred of cases of WI Department of Regulation and Licensing

Medication Diversion

- Types of drugs preferred:
  - Only 20% of nurses admit to using more than one prescriptive-type drug, most use only 1 drug:
    - 60% use an opiate
    - 45% use a tranquilizer
    - 11% use sedatives
    - 3.5% use amphetamines
    - 1.9% use inhalants

(Data from Story, 1998; Fallon, 2001; Griffith, 1999; Trinkoff, Story, & Wall, 1999)
Medication Diversion

- Access! Access! Access!
- Nurses who perceive an availability, administer drugs daily and perceive poor to non-existent workplace controls have 2 times the odds of drug misuse.
- Each of these variables exert individual influence on use.
- Knowledge of drugs serve to promote self-medication—not curb the addiction issue.

Medication Diversion-Interventions

- Use proactive approach for early detection and intervention
- Discourage diversion through education and awareness
- Intervene as appropriate—report to Charge RN, DON, NHA
- Determine facts and begin investigation
- Investigation of facts:
  - Chart Reviews
  - Narcotic Comparisons

Medication Diversion- Interventions

- Employee tested for cause and placed on leave
- Report to employee of results
- Employee interviewed if requested by team
- Finalization of investigation and decision of team reported
- Employee notified of findings and disposition
- Required reporting to authorities:
  - Pharmacy to DEA, Pharmacy to Pharmacy Board, Employee to Nursing Board, Police

Med Diversion When to call DON and Pharmacy

Unresolved discrepancies
- Questionable resolutions
- Tampered syringes or vials
- Misplaced narcotics
- Missing narcotics
- Missing patient home supply medications
- Misplaced sharps
- Suspicious behavior
- Intervention is immediate if suspect is believed to be at work and impaired

Med Diversion- The Intervention

- The Intervention
- Usually 2-3 hours after shift begins
- Suspect is asked to explain discrepancies or explain behavioral concerns
- Suspect is asked to account for all discrepant medications
- Suspect is placed on administrative leave and taken to employee health for urine drug screen analysis

Med Diversion- Lessons Learned

- If you are not finding any drug diversion you are not looking
- Early intervention is vital for both patient care concerns and health care employee professional recovery
- A visible program is a major deterrent to diversion
- Review in orientation that you have a Medication Diversion Program in place
Challenges Facing Healthcare

- Government Reform
- Reimbursement Changes
- Increased Costs
- Regulatory Changes

Challenges: Health Care Reform

- Patient Protection and Affordable Care Act (PPACA) or also called ACA
- Signed into effect March 23, 2010
- Reform Private Insurance
- Reform Public Insurance
- Improve coverage to those with pre-existing conditions
- Expand access to care
- Reduce long term costs of health care

Challenges: Government Response

Medicare and Medicaid Reform

- Decrease Reimbursement
- Lower Medicare Costs

Destination: Rehospitalization

Start 2010
Arrival 2012
Background

- Reimbursement drives the healthcare system
- Over the years resulted in decreased length of stay
- Medicare continued to look for ways to contain costs. Studied
  - Admissions
  - Discharges - delayed due to waiting for LTC bed
- Discovered
  - High numbers of preventable readmissions

Rehospitalization Defined

- Unanticipated
- Unscheduled
- Clinically related to the initial admission
- Can be readmitted to a different hospital – not just original hospital

Hospitalization Defined

- Definitions of Hospital Readmissions
  - "...patients who are discharged from acute care hospital and are hospitalized again within 30 days of discharge."
- Some readmissions may be unavoidable. Other readmissions may be avoidable, but nevertheless occur, due to a lack of follow-up care coordination or some other problem

Hospital Readmission Reduction Program

- Medicare will “recover” payments for unnecessary readmissions/30 days of discharge
- Medicare is not paying for readmissions within 24 hours of discharge
- Readmission is defined as: Being admitted at the same or different hospital within 30 days of discharge, for certain applicable conditions

Cost of Readmission

- What is the cost of a vacant bed or beds at your SNF?
- Average rate of $400/day x 30 days = $12,000 for every empty SNF bed (Related to unplanned hospitalizations or reduction in referrals from hospitals)
- What is the cost of high return to hospital rates that impact on the hospital performance? expectations?

Medicare Costs

- Hospital readmissions within 30 days of discharge cost Medicare $17.4 billion in 2010
- One quarter of patients readmitted to the hospital within 30 days of discharge were in skilled nursing facilities for recuperative or rehabilitative services.
Hospital Readmission Reduction Program (HRRP)

- According to the Institute for Healthcare Improvement (IHI), “there are about 5 million hospital readmissions annually. “
- 46% could be prevented
- The Journal of Hospital Medicine identified that 1 in 5 Medicare patients readmit in 30 days. It is estimated 25-30% from LTC

Operational Strategy One
Prepare For Change

- The Centers for Medicare & Medicaid Services (CMS) estimated
  - Cost of avoidable readmissions > than $17 billion a year.
- CMS will reduce payments for readmissions
  2013 - 1% total Medicare billings
  2014 - 2%
  2015 – 3%
- Medicare hopes to reduce readmissions by at least 25%, believing 30% - 67% of all re-hospitalizations can be avoided.

As of October 1, 2012

- First 3 Conditions
  - Heart Attack (AMI) – Acute Myocardial Infarction)
  - Pneumonia
  - Heart Failure
- 235 Diagnostic categories were reviewed
- CMS indicates -total admissions and readmission to acute
  - Heart failure (1st)
  - Pneumonia (2nd)
  - AMI (9th)

What Accountability Means for the Accountable Care Organization

Preconditions for an ACO:
- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care.

Preconditions include:
- Enrollment of an identified population
- Commitment to universality for its members
- The existence of an organization that accepts responsibility for all three aims for that population.

The Potential Impact

- Hospitals will receive bundled payments covering not just the hospitalization, but care for the 30 days after the hospitalization.
- Hospitals with high rates of readmission will be paid less if patients are re-admitted to the hospital within the same 30-day period.
- Therefore, the performance of LTC facilities and how they manage post hospital admissions will be critically evaluated by hospitals
- This includes how LTC facilities manage discharges to home from the SNF
Hospitals Rely on Transfer Success

- Hospitals will want to work with facilities that readmit less often to avoid losing reimbursement
- This means more than just taking what comes

What can you do to become a trusted partner?

SNF Performance Affects Referrals

Hospitals are tracking Nursing Facility readmission rates

# of residents re-hospitalized (within 30 days of admission to the nursing facility)

\[
\frac{\text{Total number of hospital admissions}}{5/25} = 0.2 \\
0.2 \times 100 = 20\%
\]

Safety & Quality of Post Acute Care

- Focus on the transfer process from acute care to post-acute care facilities
- Communication & cooperation between skilled nursing facility & other post-acute venues during discharge process directly impacts on the safety & success of the transfer
- Align with partners sooner not later: Hospitals, Physicians, Home Health, Assisted Living Facility and Hospice

Benefits of Saving

If Accountable Care Organizations provide high quality care and reduce costs to the health care system, they can keep some of the money that they have helped save.

Why Focus on Readmissions?

“According to the Institute for Healthcare Improvement (IHI), “there are about 5 million hospital readmissions annually. “
- 46% could be prevented

According to Journal of Hospital Medicine
- 1 in 5 Medicare patients readmit in 30 days. February 2011

Rehospitalizations

Historically no disincentives

Some hospitalizations are necessary, some are not
Not Just for Hospitals

Just announced... February 14, 2012

“In order to tackle rehospitalizations, Obama's plan proposes reducing “SNF payments by up to 3% beginning in 2016 for facilities with high rates of care-sensitive, preventable hospital readmissions.”

First 3 Conditions to be Monitored October 2012

- Affordable Care Act (ACA)
  - Heart Attack
  - Pneumonia
  - Heart Failure

- Medicare will “recover” payments for unnecessary readmissions within 30 days of discharge if the patient has one of the above 3 conditions

Contributing Factors for Readmissions to Hospital from Skilled Care

- Hosp. Length of stay (1969: 10.6 days / 2011 6.4 days)
- Weekend Admissions from LTC to hospital
  - Primary MD not available
  - On-calls reluctant to write orders
  - No medical assessment onsite on w/e
- Medicare auditors tend to question MD billing for frequent SNF visits vs. hospital visits for acutely ill residents

Rehospitalization Effect on Resident

“Relocation Stress Syndrome”

- “A consequence of the stress and emotional shock caused by an abrupt relocation of a resident from one location to another.”

- Increased dependence on staff, delirium, depression, anger, withdrawal, change in behavior, change in sleep pattern, insecurity, loss of trust, weight loss, falls.

Some Inappropriate Readmissions from Skilled to Acute Care

- Falls
- Change in functional ability
- Level of consciousness change
- Pain
- New Weakness
- Weight/eating patterns

Contributing Factors for Readmissions from Skilled Care

- No comprehensive review of the new admit
- Lack of geriatric assessment skills (Lung and heart sounds etc.) in nursing staff
- Missed identification of acute change in condition (all staff)
- Infection control issues/monitoring for infections
- Lack of training in IV therapy
Contributing Factors for Readmissions From Skilled Facilities

- Response time longer from MD/NP/Specialists
- Less experienced work force or weekend only staff
- Not knowing the patients
- Fewer supervisors
- Supervising staff they don’t know
- Higher call off numbers
- Most common day of the week to discharge from a hospital is Friday

Key Operational Strategies

- Conduct Research and Prepare for Change
- Develop an Interdisciplinary Team Task Force
- Assess Organization Systems
- Assess Clinical Readiness
- Benchmark Data – Strategic Partnerships and facilitation of Quality Plans

What do I do at the Facility Level?

- Coordinate with Acute Care/Providers
- SNF will need to provide enhanced clinical services
  - Nurse Practitioners in SNF
  - Support better transitions between hospital and SNF – Care transitions, Preadmission assessments, Admission care and assessments
  - Ensure staff are adequately trained

What to do at the Facility Level?

- Implement best practices to prevent:
  - Falls
  - UTI/Infection Prevention
  - Pressure Ulcers
  - Train and Perform Competency
  - Head to toe assessments
  - Cardiac
  - Respiratory

What do I do at the Facility Level?

- Develop protocols for monitoring residents and for change in condition
- Educate staff
- Educate residents
- Review discharge/transition planning processes
- Medication review
Readmission Task Force

- Know history of re-admissions
- Which ones could have been prevented
- Identify strengths and opportunities in your admission process
- Review current policies and procedures, amend as needed
- Review procedures for obtaining advanced directives
- Identify staffing needs, i.e., weekend supervisor

Readmission Task Force

- Teach managers or supervisors how to do a thorough chart review on all new admissions
- Perform medication review and clarify with MD/NP
- Involve consultant pharmacist

Congratulations!!

- You made it through Session II!