



National Nursing Home

QUALITY IMPROVEMENT
CAMPAIGN

Change Package: All Cause Harm Prevention in Nursing Homes

January 24, 2019



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





National Nursing Home

QUALITY IMPROVEMENT CAMPAIGN

The National Nursing Home Quality Improvement Campaign (NNHQIC) *(formerly known as Advancing Excellence)*

- Supports long-term care providers, consumers and their advocates, and quality improvement professionals
- Established in 2006 with a group of stakeholders including CMS, CDC, VA, the Joint Commission, AHCA, Leading Age, AMDA, NADONA & AANAC, the Consumer Voice, and many others
- Today, the Campaign is funded through CMS and operated by Telligen

www.nhQualityCampaign.org
help@nhQualityCampaign.org



Campaign Overview

- Provides no cost evidence-based and model-practice resources to support data-driven quality improvement projects in long-term care settings.

**Resources
& Ideas**

**Tracking
Tools**

**Graphs &
Reporting**

- Promotes focus on individuals' preferences, staff member empowerment, and involving all staff members, consumers, and leadership in creating a culture of continuous quality improvement.

*In August 2016, the Advancing Excellence in Long Term Care Collaborative turned over the operation of the Advancing Excellence in America's Nursing Homes Campaign to CMS. The Campaign has been renamed the National Nursing Home Quality Improvement (NNHQI) Campaign.



Agenda

Change Package: All Cause Harm Prevention in Nursing Homes

Welcome & Introduction

Adrienne Mihelic, PhD

Program Manager | NNHQI Campaign

CMS Leadership Introduction

Angel Davis, MBA, MS, BSN, RN

QIN-QIO Nursing Home Subject Matter Expert | CMS,

Overview of the Change Package

Kelly O'Neill, RN, BSN, MPA, CPHQ

Program Manager | QIN NCC

Panel Discussion

Lina A Dureza, RN, BSN, LNHA, MSM Administrator &

Sandra Dinnall-Nevin, RN

Hughes Health and Rehabilitation, West Hartford, CT

Linda Dorado, RN

Director of Nursing | Phoenix Mountain Nursing Center,

Phoenix, AZ

Questions & Sharing

All



Let's begin...

- Engage and attend
- Challenge your assumptions
- Listen for ideas, strategies, actions you might try
- Ask questions
- Share stories

Meet your Speaker (1 of 2)



Angel Davis, MBA, MS, BSN, RN
QIN-QIO Nursing Home
Subject Matter Expert, CMS

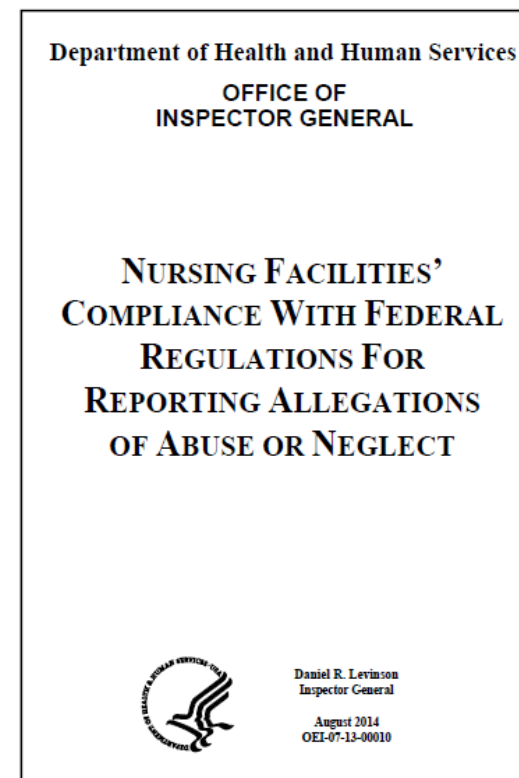
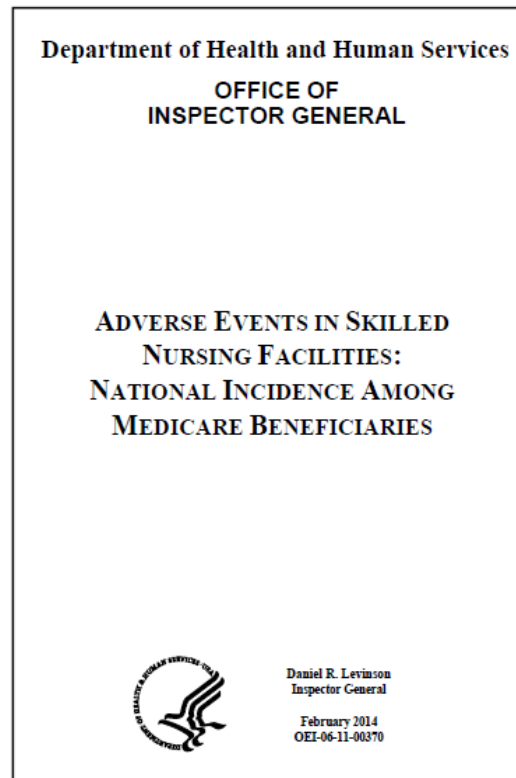
Meet your Speaker (2 of 2)



Kelly O'Neill, RN, BSN, MPA, CPHQ
Nursing Home SME
Quality Innovation Network
National Coordinating Center

Need for Focus on All Cause Harm Prevention in Nursing Homes (NHs)

2014: Key reports from the Office of Inspector General



Levinson, Daniel (2014, February). Adverse Event in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries. Retrieved from <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>

Levinson, Daniel (2014, August). Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect. Retrieved from <https://oig.hhs.gov/oei/reports/oei-07-13-00010.pdf>

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries

- An **estimated 22%** of Medicare beneficiaries experienced adverse events during their SNF stays.
- An **additional 11%** experienced temporary harm events during their SNF stays.
- **59%** of these events were clearly or likely preventable.
 - Much of the preventable harm attributed to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.
 - Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of \$208 million in August 2011. This equated to **\$2.8 billion** spent on hospital treatment for harm caused in SNFs in FY 2011.

Nursing Facilities' Compliance with Federal Regulations for Reporting Allegations of Abuse or Neglect

It is required that nursing facilities will report any and all allegations of abuse or neglect to ensure resident safety.

- **85 percent** of nursing facilities reported at least one allegation of abuse or neglect to OIG in 2012.
- **53 percent** of allegations of abuse or neglect and the subsequent investigation results were reported, as federally required.

Purpose of the Change Package

- To identify and share practices that appear to contribute to prevention of all cause harm, to rapidly spread these practices to NHs across the country
- To serve as a key resource to improve quality of life through safer care for the 1.4 million NH residents across the country, as NHs work to prevent, detect, and mitigate harm while honoring each resident's rights and preferences
- To support all NHs in choosing from strategies and actions to begin testing for purposes of improving residents' quality of life through safer care

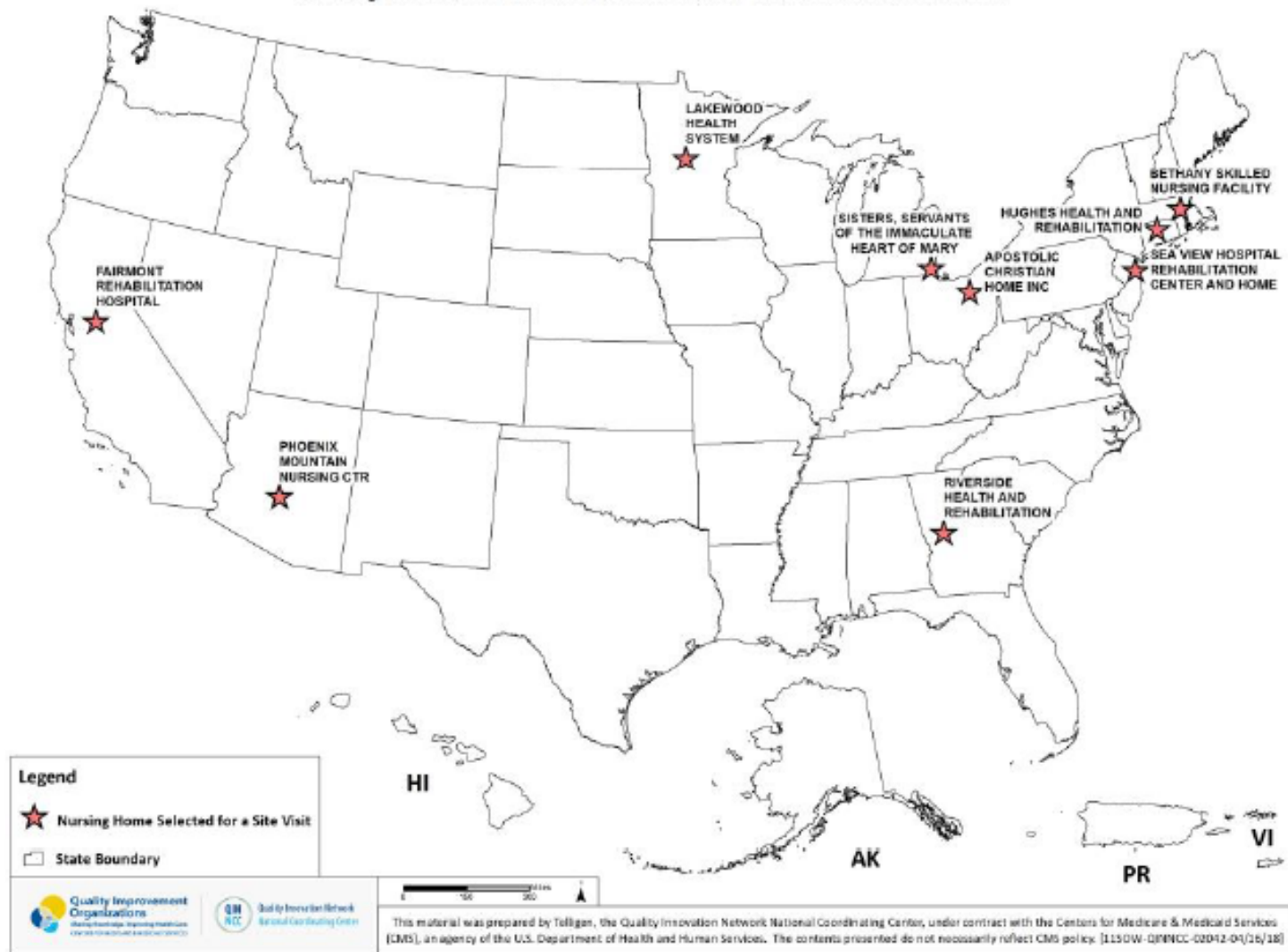
Overview: Change Package Development Process

Sept 2017 – June 2018

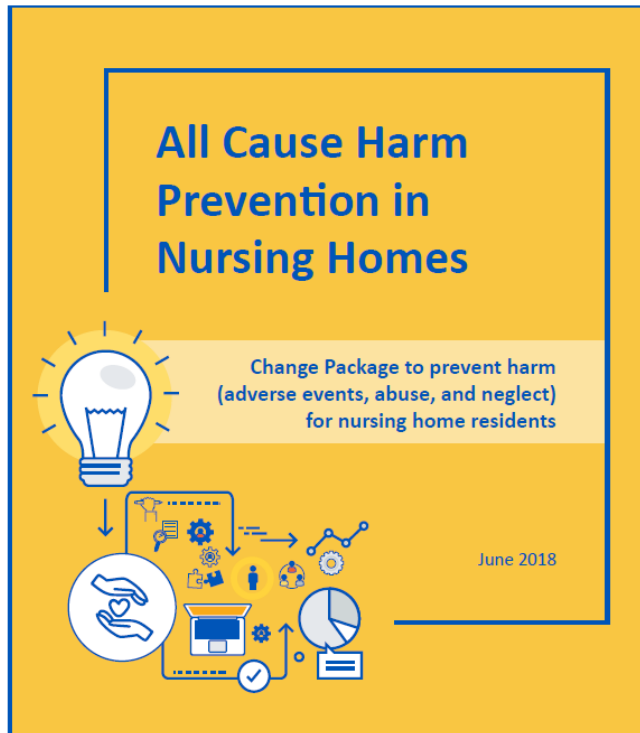
- Conducted a literature review on all cause harm
- Established an analytic algorithm and vetting process to identify nursing homes eligible for site visit
- Conducted nursing home site visits, using qualitative appreciative inquiry approach, and debrief sessions
- Utilized an Expert Panel to develop a Change Package compiled from site visit findings

Participating Nursing Homes

Nursing Home Best Practice Site Visits: All Cause Harm Prevention



Change Package



- Focused on successful practices of high-performing NHs
- Strategies and actions range from evidence-based practices to promising practices
- <https://qioprogram.org/all-cause-harm-prevention-nursing-homes>

Intended Audience

- Nursing homes participating in the National Nursing Home Quality Care Collaborative, led by the Centers for Medicare & Medicaid Services (CMS) and the Medicare Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), and
- Anyone interested in improving the quality of life and quality of care for those living in nursing homes

Change Package Organization: Foundational Components

- Four overarching foundational components
 - Leadership
 - Committed staff, teamwork, and communication
 - Resident and family engagement
 - Continuous learning and quality improvement

Improved Quality of Life Through Safe Care



Specific Harms and Adverse Events Discussed in the Change Package

Adverse Events Identified by OIG

Types of Adverse Events	Percentage*
Events Related to Medication	37%
<ul style="list-style-type: none"> Medication-induced delirium or other change in mental status Excessive bleeding due to medication Fall or other trauma with injury secondary to effects of medication Constipation, obstipation, and ileus related to medication Other medication events 	<ul style="list-style-type: none"> 12% 5% 4% 4% 14%
Events Related to Resident Care	37%
<ul style="list-style-type: none"> Fall or other trauma with injury related to resident care Exacerbations of preexisting conditions resulting from an omission of care Acute kidney injury or insufficiency secondary to fluid maintenance Fluid and other electrolyte disorders (e.g., inadequate management of fluid) Venous thromboembolism, deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring Other resident care events 	<ul style="list-style-type: none"> 6% 6% 5% 4% 4% 14%
Events Related to Infections	26%
<ul style="list-style-type: none"> Aspiration pneumonia and other respiratory infections Surgical site infection (SSI) associated with wound care Urinary tract infection associated with catheter (CAUTI) <i>Clostridium difficile</i> infection Other infection events 	<ul style="list-style-type: none"> 10% 5% 3% 3% 5%
Total	100%

Temporary Harm Events Identified by OIG

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

Change Package Organization: Strategies and Actions to Prevent Specific Types of Harms

Each section includes the following components:

- a) Foundational and ongoing education topics to consider
- b) Pre-admission practices
- c) Admission practices
- d) Ongoing care practices and monitoring
- e) Resources to consider

Example: Prevent Excessive Bleeding Due to Medication (Antithrombotics)

Prevent excessive bleeding due to medication (antithrombotics)

Foundational and Ongoing Education Topics to Consider

- ❑ Educate nurses on different types of antithrombotics which include both anticoagulants (e.g., warfarin and newer agents) and antiplatelet agents (e.g., aspirin, clopidogrel). This education should include: risks associated with each type of medication, foods and other commonly used medications that could impact effectiveness, which agents require regular monitoring, and which agents can be reversed if severe bleeding was to occur. For warfarin, include education on the role of the INR testing and maintenance therapy.
- ❑ Educate nursing assistants on symptoms to watch for that may indicate bleeding (e.g., bruising, bleeding, swelling, pain, discoloration anywhere on the body, sudden headache, dizziness, weakness, blood in urine, or black stools).
- ❑ Educate staff on using a gentle and calm approach when assisting residents with moving or activities of daily living (e.g., dressing, personal care, eating), so as not to cause any trauma to the residents skin, joints, etc.

Pre-Admission Practices

- ❑ Review anticoagulant use and monitoring, and determine when labs were performed, the most recent results from the discharging facility, and when the next labs are due.
- ❑ Discuss history of antithrombotic use with the resident and family (e.g., how long they have been taking, how they have been monitoring, any concerns or complications).

Admission Practices

- ❑ Have facility attending physician/practitioner review antithrombotic medication use to ensure appropriate continued use.
- ❑ Nurses reconcile medications on each shift for the first 24 hours (e.g., reconcile admission orders, transfer orders, discharge orders, and medication administration record).
 - Include review and reconciliation of antithrombotic medication orders. Follow up with provider on questions or missing information.
- ❑ Discuss and review the medication plan with the resident (and family as applicable) so that they know what to expect and can help monitor consistent implementation of the plan.
- ❑ Establish a process upon admission to obtain the resident's latest lab results (from previous setting) and to set up lab work as ordered.
- ❑ Establish a system that alerts nursing staff to watch for specific adverse side effects for medications.
- ❑ At daily stand up/IDT meeting, review new resident's admission antithrombotic medications and potential or observed side effects.
- ❑ Add warfarin to 24-hour report and ensure it is reviewed with all staff at shift change (appropriate staff and IDT team members should review 24-hour reports back to the last day worked in order to ensure they are aware of changes).

EVENTS RELATED TO MEDICATION

Ongoing Care Practices and Monitoring

- ❑ Promote the use of standardized protocols (e.g., nurse or pharmacist run anticoagulation clinic to monitor and adjust dosage of anticoagulant agents).
- ❑ Have a process to weigh the risks and benefits of each type of antithrombotic agent to help determine the best choice for each resident (e.g., warfarin as compared to newer agents).
- ❑ Establish alerts for nursing staff and providers for medications that can interact with antithrombotics (e.g., antibiotics, antifungals, aspirin, ibuprofen, antacids).
- ❑ Involve the dietician in helping the resident and family to understand how certain foods and beverages can make anticoagulants less effective in preventing blood clots, or beverages that can increase the effects of warfarin, and to assist with menu planning.
- ❑ Establish alerts for nursing staff and providers regarding fall risk implications for residents on antithrombotics (staff needs to know if a person taking an antithrombotic falls as they are at even greater risk for bleeding).
- ❑ Add anticoagulant medication changes that need monitoring to 24-hour report and ensure it is reviewed with all staff at shift change (appropriate staff and IDT team members should review 24-hour reports back to the last day worked in order to ensure they are aware of changes). The key is to have a process to notify staff if there have been significant changes.

Resources to Consider

- ❑ American Heart Association, A Patient's Guide to Taking Warfarin - http://www.heart.org/HEARTORG/Conditions/Arrhythmia/PreventionTreatmentofArrhythmia/A-Patients-Guide-to-Taking-Warfarin_UCM_444996_Article.jsp#Wvn7YjfruUk
- ❑ CDC Healthcare Professionals: Training and Education, Stop the Clot®: What Every Healthcare Professional Should Know - <https://www.cdc.gov/ncbddd/dvt/training.html>
- ❑ See [Appendix D](#) for suggestions on team members in your organization to include in quality improvement efforts for this topic.

EVENTS RELATED TO MEDICATION

Change Package Organization: Appendices

- A. Need Ideas for Where to Start? Focus Here First
- B. Foundational Components that Support Staff in Carrying Out Actions to Prevent Harm (Adverse Events, Abuse, and Neglect) for Nursing Home Residents
- C. OIG Report Findings
- D. Team Members to Consider and Resources for Quality Improvement Efforts

Meet Your Panelists



Lina A Dureza
Administrator
Hughes Health &
Rehabilitation
West Hartford, CT



Sandra Dinnall-Nevin
Registered Nurse
Hughes Health &
Rehabilitation
West Hartford, CT



Linda Dorado
Director of Nursing
Phoenix Mountain
Nursing Center
Phoenix, AZ

Panel discussion (1 of 6)

How would you go about reviewing this Change Package - identifying opportunities and prioritizing changes to make - what would that process look like in your organization?



**Lina A Dureza,
NHA**



**Linda Dorado,
DON**



Panel discussion (2 of 6)

What are some barriers you know that you would face in reviewing the CP, identifying opportunities for improvement, prioritizing changes to make? What would you do to work through those?



**Lina A Dureza,
NHA**

Panel discussion (3 of 6)

How do you see this aligning with other priorities (QAPI, infection prevention regulations, etc.) in your organization? How does the information in the Change Package to prevent harm help you make improvements in those priority areas?



Sandra Dinnall-Nevin, RN

Panel discussion (4 of 6)

What is different about this resource - don't we already have all of this information in other places? How will this Change Package be helpful?



**Linda Dorado,
DON**

Panel discussion (5 of 6)

Even if you make some changes, how do you get them to stick? It is common to revert back to old habits.



**Lina A Dureza,
NHA**



**Linda Dorado,
DON**

Panel discussion (6 of 6)

How do you balance safety with honoring rights and preferences of residents? Sometimes honoring resident preferences can jeopardize their safety.



Sandra Dinnall-Nevin, RN

Feedback, Questions, and Reflections

Chat in your questions and comments.

Press *1 on your telephone key pad to enter the teleconference queue.





Announcement

MLN CALL Tuesday March 12, 1:30pm ET

National Partnership to Improve Dementia Care and Quality Assurance
Performance Improvement (QAPI)

Dementia Care & Psychotropic Medication Tracking Tool

Learn about the National Nursing Home Quality Improvement Campaign's new Dementia Care & Psychotropic Medication Tracking Tool. This free, publicly available electronic tool facilitates a structured approach to tracking preference-based care and psychotropic medication use among individuals living with dementia.

[REGISTER NOW](#)



Related resources from the QIO Program

- Change Package: All Cause Harm Prevention in Nursing Homes
<https://qioprogram.org/all-cause-harm-prevention-nursing-homes>
- Tool Collection to Implement QAPI
<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/ProcessToolFramework.pdf>
- Training Modules on Antibiotic Stewardship & C. difficile
<https://qioprogram.org/nursing-home-training-sessions>
- Facility Assessment Tool
<https://qioprogram.org/facility-assessment-tool>



National Nursing Home Quality Improvement Campaign

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work, and visit!

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