Effective Tools to Prevent and Manage Adverse Events: Lesson 2

Based on the Office of Inspector General Adverse Events Report February 2014

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Objectives

Upon completion of this second lesson of a 3 part module, the participant will be able to:

Module 2 Lesson 2

- Identify strategies for proactively preventing and identifying adverse events in the areas of medication, infection, and cares
- Implement strategies to prevent, identify, and manage adverse events
Adverse events

- Congress Mandated Report
- Studied 653 Medicare Beneficiaries who transitioned from hospital to SNF PAC
- Found:
  - 22% experienced an adverse event
    - Over 50% returned to the hospital
    - An additional 11% experienced a temporary harm event
- Cost of Care
  - $208,000,000 in August of 2011
  - 2,800,000,000 annualized for 2011
- It is also noted that 70% of Medicare Beneficiaries will have a post acute care stay
Adverse events by clinical category

- Infection Events 26%
- Medication Events 37%
- Care Related Events 37%
- Better recognition of the problem is needed
- Improved documentation of the response
- Increased accountability for prevention
Adverse events definition

- “Harm to a patient as a result of medical care”
- This includes:
  - Failure to provide needed care
  - Medical errors in general
  - More general substandard care
    - e.g., infection from use of contaminated equipment
- Adverse events do not always involve errors, negligence, or poor quality of care
- Adverse events may be unavoidable
Adverse event: “cascade event”

- “An event that included a series of multiple, related events.”
- Excessive Anti-coagulation
- Polypharmacy creating fall risk
- Single drug causing multiple adverse events
  - e.g. Anticholinergic class drugs
Temporary harm events

- Medication 43%
- Resident Care 40%
- Infections 17%
Temporary harm: medication related

- Hypoglycemic episodes
- Fall or other trauma with injury r/t meds
- Medication-induced delirium or other change in mental status
- Thrush and other nonsurgical infections related to medication
- Allergic reactions to medications
- Other medication events
Temporary harm: resident care

- Pressure ulcers
- Fall or other trauma with injury associated with resident care
- Skin tear, abrasion, or breakdown
- Other resident care events
Temporary harm: infections

- CAUTI
- Surgical site infection (SI) associated with wound care
- Other infection events

- Early recognition is essential!
AD and temporary harm events by preventability rationales

- Treatment provided in a substandard way or not provided
- Resident’s progress not adequately monitored
- Error r/t medical judgment, skill, or resident management
- Resident care plan was inadequate, incomplete, lacking clear description of condition
- Health status was not adequately assessed.
Proactive quality management

- QAPI: Quality Assurance Process Improvement
  - Design and Scope
  - Governance and Leadership
  - Feedback, Data Systems and Monitoring
  - Performance Improvement Projects (PIP’s)
  - Systematic Analysis and Systemic Action

QAPI Resources:
http://cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/NHQAPI.html
QAPI Resources

CMS strives to provide nursing home providers with access to resources (materials or websites) to support QAPI implementation. Use of these resources is not mandated by CMS for regulatory compliance nor will it assure regulatory compliance.

Guides to Quality

Getting Better All the Time: Working Together for Continuous Improvement

The Isabella Geriatric Center and Cooke Hill Health Center have developed a web manual on quality improvement approaches and a guide for nursing home caregivers. This is a particularly practical and lively resource that explains and illustrates performance monitoring and improvement approaches in ways that are understandable to most nursing home caregivers. Getting Better All the Time was written by Ann Wyatt, a social worker and nursing home administrator, it aims to present a model of quality improvement that integrates quality of care and quality of life. Click here to access Getting Better All the Time.

Implementing Change in Long-Term Care: A Practical Guide to Transformation

This resource was prepared by Barbara Bowers and others with a grant from the Commonwealth Fund to the Pioneer Network. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process. Click here to access Implementing Change in Long Term Care.

National Nursing Home Quality Care Collaborative Change Package

The National Nursing Home Quality Care Collaborative (NNHQC) Change Package is a menu of strategies, change concepts, and specific actionable items that nursing homes can choose from to begin testing for purposes of improving residents’ quality of life and care. The Change Package was originally intended for nursing homes participating in the National Nursing Home Quality Care Collaborative led by CMS and the Medicare Quality Improvement Organizations (QIOs), to improve care for the millions of nursing home residents across the country. The Change Package was developed from a panel of top experts in nursing homes across the country, and for those that owned nursing homes.
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<td>where staff are comfortable identifying quality problems and opportunities</td>
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<td>• Create a learning organization that drives and reinforces a process for organizational change</td>
<td>• Distinguish between human error, at risk, and reckless behavior, and respond differentially/appropriately to each</td>
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Proactive quality management
Proactive quality management (culture of safety)

- **TeamSTEPPS® Long-Term Care Version**

- The Essentials Course highlights the key principles and concepts of TeamSTEPPS (Strategies & Tools to Enhance Performance and Patient Safety). The Essentials Course can bring you up to speed quickly about improving resident safety by implementing TeamSTEPPS.
Weblinks to TeamSTEPPS LTC Version

- AHRQ STEPPS Program for LTC: www.teamstepps@ahrq.gov
- AHRQ LTC STEPPS Program
TeamSTEPPS® Long-Term Care Version

The Long-Term Care version of TeamSTEPPS adapts the core concepts of the TeamSTEPPS program to reflect the environment of nursing homes and other long-term care settings such as assisted living and continuing care retirement communities. The examples, discussions, and exercises below are tailored to the long-term care environment. Keys to success at each phase include involvement of the right people, use of information-driven decision making, and careful planning before acting. The following paragraphs provide an overview of each of the phases including goals and objectives, key actions, and recommended tools and resources.

Overview

The Department of Defense (DoD) and the Agency for Healthcare Research and Quality (AHRQ) have developed TeamSTEPPS, a teamwork system that offers a powerful solution to improving collaboration and communication within health care facilities. Teamwork has been found to be one of the key initiatives within patient safety that can transform the culture within health care. Patient safety experts agree that communication and other teamwork skills are essential for the provision of quality health care and for the prevention and mitigation of medical errors and patient injury and harm. This version of TeamSTEPPS has been adapted to address issues specific to nursing homes.

TeamSTEPPS is an evidence-based program aimed at optimizing performance among teams of health care professionals, enabling them to respond quickly and effectively to whatever situations arise. This curriculum was developed by a panel of experts, incorporating over 25 years of scientific research that has been conducted on teams.
Adverse and temporary harm events by preventability rationales

- Appropriate treatment was substandard
- Resident’s progress not adequately monitored or communicated
- Necessary treatment was not provided
- Error r/t medical judgment, skill, or management
- Resident care plan was inadequate, incomplete, in sufficient
- Health status was not adequately assessed.
Preventability factors

- Preventability Factors:
  - Proper procedures followed
  - Patient highly susceptible
  - Could not have anticipated
  - Patient’s condition complex
Preventability factors

- Proving “Unavoidability”
  - Comprehensive Assessment & Identification of Individual Resident Risk Factors
  - Care planning based on the comprehensive assessment
  - Delivery of the care plan
  - On-going re-evaluation of outcomes and adjustments to the care plan
  - Progress notes noting identification of indicators and actions taken
- Interdisciplinary Team (IDT) progress note outline challenging situations and all actions taken and their result
Proactive processes

- Clear admission criteria which meets the facility’s capacity to care for complex patients
- Staff training skills needed for the type of patients you are accepting
  - What type of education processes are you using?
- Is critical thinking enhanced by simulation training?
Proactive processes

- Do staff know the warning signs of early onset adverse events?
- Is staffing adjusted based on acuity?
- Would clinical decision software assist in guiding staff?
- Do you review negative outcomes through a RCA process?
- Medical care accessible or accessed?
Identification

Know the risk factors for adverse events:
- 1st 48 hours after hospital transfer/admission
- Transfers on Friday afternoons
- Lack of critical thinking by frontline nursing staff
- Lack of close communication among CNA’s, nursing and other NH staff and between nursing home staff and physicians/APRN

Know the warning signs
Assessing harm

- Did an event occur?
- What was the level of harm?
- Is this a case of omission or commission?
- Was the event preventable?

NCC MERP is the National Coordinating Council for Medication Errors Reporting and Prevention
“We can only get the most complete, credible and useful information by studying structure, process and outcome in conjunction” (Donabedian, 1980)
Root Cause analysis

- Timeline starting with the event and working back
- Determine what happened – what is the problem to solve
- Determine why it happened – identify causes
- Start the 5 Why’s
- Figure out actions to take to reduce recurrence
- Examine existing process & structure r/t event to identify gaps
Adverse events: Infection related

- Resulted in:
  - 36% of hospital readmissions from a SNF within 30 days
  - 25% of all hospitalizations from 32 nursing homes in a one year time period
  - Increased morbidity r/t hospital transfers such as delirium, PU, functional decline
  - Increased cost of care

Adverse events: Infection related

- C-difficille
- Urinary Tract Infection (UTI)
- Catheter Associated UTI
- Septicemia
- Pneumonia and Respiratory Tract
- Surgical site Infection – superficial only
- Soft tissue and Other
- Vascular Device associated infection

Adverse events: Infection related

- Surveillance
- On-going tracking
- Daily tracking for outbreaks
- Measure infections per 1000 resident days and per 100 admissions
- Anti-microbial Stewardship
Adverse events: Infection related

- Pharmacy consultant DRR always looking at antimicrobial use
- Right use of the right type of disinfectants – who is selecting your disinfectants?
- Staff can articulate the kill time and when to use what disinfectant
- Is rehab using disinfectants on shared equipment?
Adverse events: Infection related

National Infection Reporting System from National Healthcare Safety Network

- [www.cdc.gov/nhsn/ltc](http://www.cdc.gov/nhsn/ltc)

HHS National Action Plan to Prevent HAIs: LTC Chapter

- [www.hhs.gov/ash/initiatives/hai/actionplan/index.html](http://www.hhs.gov/ash/initiatives/hai/actionplan/index.html)

National Action Plan to Prevent Health Care Associated Infections: Road Map to Elimination:


Advancing Excellence:

- [https://www.nhqualitycampaign.org](https://www.nhqualitycampaign.org)
HHS National Action Plan to Prevent HAIs: LTC Chapter

http://www.hhs.gov/ash/initiatives/hai/actionplan/index.html
Adverse events: Medication Related

- Medication Reconciliation
- Drug Regimen Review
- ACE Inhibitors (Acute Kidney Injury)
- Insulin (hypoglycemia)
- Loop diuretics (hypokalemia)
- ACE inhibitors / ARB’s (hyperkalemia)
- Loop diuretic and SSRI’s 3.7% (Hyponatremia)
Adverse events: Medication related

- 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
Adverse events: medication related

- Expectations and utilization of the pharmacy consultant and the drug regimen review process
- Sound medication reconciliation processes
Adverse events resident care related

- Fall /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
Adverse events resident care related

- Fluid and other electrolyte disorders (e.g. inadequate management of fluid)
- Deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring
- Other resident care events
Adverse events: care related

“Monitoring” refers to:
- inadequate laboratory evaluation of drug therapies or
- delayed response or
- failure to respond to signs or symptoms of drug toxicity or
- laboratory evidence of toxicity.

Often related to transitions (poor communication and errors of omission and commission)
Fall prevention and management

- RCA Tools
- AHCA Managing Falls Risk and Educational Webinar
- QAPI Processes
- Wellness
- Restorative
- Sleep management
- Integrative Care
Fall prevention and management

- Muscle strengthening and balance training
- Tai Chi Chuan
- Home Hazard Assessment and modification
- Withdrawal of psychotropic medications
- Multidisciplinary, multifactorial interventions
- Resistance training improving muscle mass and strength at any age
MDS 3.0 Appendix “C”

CAA Jargon:
- Review of Indicators (risk factors)
- Disease and Conditions
- Mood and Behavior
- Functional Status
- Medications
- Environment
- Other Considerations
- “Analysis of Findings” / “Care Plan Considerations”
- (Each CAA is different)
Summary

- Create the Culture of Safety
- Manage Transitions of Care
- Medication management
- End stage disease management
- Increase facility capacity for complex residents
- Staff training – including simulation
- Excellent documentation – get credit for your actions