



# **MLN Connects<sup>®</sup>**

*National Provider Call*

## **National Partnership to Improve Dementia Care in Nursing Homes & Quality Assurance and Performance Improvement (QAPI)**

September 15, 2016



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# Agenda

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## **Effective Care Transitions between Long-Term & Acute Care Settings**

### **Panel Members –**

**Dr. Kevin Biese**, Association Professor, University of North Carolina (UNC) - Department of Emergency Medicine & Internal Medicine, Division of Geriatrics

**Tammie Stanton**, Registered Nurse, Vice President of Post-Acute Care - UNC Health Care System

**Kathryn Weigel**, Director of Nursing (DON) Rex Rehabilitation & Nursing Care Center of Apex

**Scott Bartlett**, Lead Long-Term Care (LTC) Ombudsman, Pikes Peak Area Council of Governments - Area Agency on Aging

Michele Laughman, CMS

Debbie Lyons, CMS

## **National Partnership & QAPI Updates**

# Welcome

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# Effective Care Transitions between Long-Term & Acute Care Settings

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## Panel Discussion:

Dr. Kevin Biese, Tammie Stanton,  
Kathryn Weigel, and Scott Bartlett

# Case Presentation - Background

At 3:30AM Mrs. Emily, 86 years old was found lying on the floor at the foot of the bed. When asked what had happened the resident stated “nothing happened” and denied that she was in any pain or discomfort. Mrs. Emily was admitted to the nursing home 6 weeks ago with the diagnoses of dementia, hypertension, chronic urinary tract infections (UTI) and a history of multiple falls at home. She was assisted to her feet by the staff and was able to bear weight and walk to her bed with no complaints or gait disturbance noted. Her vital signs were within normal range compared to her baseline upon admission. The resident was checked during hourly rounds with no complaints and was observed sleeping the rest of the night.

At 7:30AM, the nurse’s aide assigned to Mrs. Emily for the day shift, assisted her to the toilet and with AM care before taking her to the dining room for breakfast. The aide noted that she was not her “normal self,” meaning that she was usually pleasant and cooperative, engaging in conversation while care was provided. This morning she was “different”; slower to wake up and not as verbally responsive. The nurse contacted the provider and informed him about her fall early in the morning and her current status. An order to send Mrs. Emily to the emergency department (ED) for evaluation was obtained. The nurse called the ED to inform them that a resident was being sent for an evaluation, post fall.

At 9:00AM, Mrs. Emily arrives at the ED with a transfer sheet that lists her medications and most recent vital signs, along with a phone number for her point of contact or responsible person.

# Questions for the Panel (1)

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1. Were there steps the nursing home could have taken to potentially eliminate the need for this resident transfer?
2. To make this ED visit more productive and comfortable for the resident, what information should the nursing home have provided to the ED?

# Case Presentation – Additional Background

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The resident is evaluated and waits for the x-ray and lab work results. While in the ED, Mrs. Emily becomes anxious and attempts to climb out of the stretcher. She is also incontinent of urine. It is now 11:30AM and she has been in the ED on a stretcher for 2.5 hours. The nursing staff feel she is becoming more disoriented as the activity level of the ED rises and the constant noise from call bells and various pumps and monitors adds to sense of chaos.

# Questions for the Panel (2)

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1. What competencies or skills should the ED staff possess to effectively support expressions or indications of distress for a resident with dementia?
2. What steps can be taken to ensure that the needs of residents with dementia are supported by ED staff?

# Case Presentation – Conclusion

At 2:00PM, the x-rays and CAT scan of the head are negative, and Mrs. Emily is diagnosed with another UTI. She is medicated for pain and given a commonly prescribed antibiotic that she just finished taking, prior to her admission to the nursing home. At 4:30PM, Mrs. Emily arrives at the nursing home, agitated, confused, hungry, incontinent, and with a small reddened area on her coccyx (tailbone) that is non-blanchable. The DON contacts the provider, informing him that Mrs. Emily was given a dose of the antibiotic. The provider orders the antibiotic for 10 days, with a repeat Urine Culture and Sensitivity. Mrs. Emily's daughter stops at the nursing home, as she does every evening. When she arrives at 5:15PM, she finds her mother as described above. She had not been notified that her mother had fallen or was taken to the ED.

# Questions for the Panel (3)

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1. What are the lessons learned from this case presentation?
2. How can we change current practice in transitions of care, based upon the lessons learned?

# Lessons Learned (1)

- Explore the use of telemedicine and other innovative tools (e.g., mobile x-ray) to increase medical capacity within skilled nursing facilities and decrease transfers, when possible.
- Utilize electronic health records (EHR) to enable the review of resident information, including medications, in “real time”.
- Educate residents, their families, and/or resident representative regarding the benefits of not being transferred to the hospital or ED until appropriate triage has occurred at the nursing home.
- Communicate with the resident’s family and/or resident representative, as their availability may be necessary, as surrogate decision makers, to administer that responsibility.
- Consider carefully whether or not a resident should be sent outside of the nursing home for care when no injury or complaints of pain have been observed.

# Lessons Learned (2)

- Ensure that nursing homes complete an assessment of the resident whenever a change in condition is identified.
- Maintain open communication between nursing staff and providers.
- Perform all available tests at the nursing home before sending the resident to the ED.
- Send all pertinent information to the hospital with the resident and call the ED to provide a thorough report.
- Hold regular meetings between nursing home leadership and ED leadership to create a culture of trust and develop a shared understanding of how to best transition care for residents with dementia.
- Refine these relationships to generate a collaborative environment where data, best practices, lessons learned, and innovative successes can be shared between nursing homes and hospitals.

# Lessons Learned (3)

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- Consider the involvement of LTC Ombudsman who advocate for residents and help resolve issues, such as lack of communication between LTC providers, residents and family, and acute-care settings, during transitions of care.
- Involve the consultant pharmacists throughout the care transition process.
- Utilize the Geriatric ED Guidelines (<https://www.acep.org/geriedguidelines/>) to help EDs improve care for older adults.
- Identify possible unmet needs that a resident with dementia may communicate through expressions or indications of distress, when they are no longer able to verbalize their needs.

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# National Partnership & QAPI Updates

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Michele Laughman

Debbie Lyons

Centers for Medicare & Medicaid Services

# Question & Answer Session

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# Acronyms in this Presentation

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- UNC - University of North Carolina
- DON - Director of Nursing
- LTC - long-term care
- UTI - urinary tract infection
- ED - emergency department
- EHR - electronic health records

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