President’s Message

Why your nursing home should have an ethics committee

by David E. Fuchs, MD, CMD, defuchs@comcast.net; (717) 898-2900

Does your facility have an ethics committee? Why should they? Ethical dilemmas abound in long term care. End-of-life issues and questions regarding the appropriateness of aggressive medical interventions tend to create more anxiety among clinicians than most any other potential ethical quandary. A good functioning ethics committee can serve as both an educational tool for the facility as well as a supportive resource for clinical decision making.

Although POLST and advance directives assist in understanding the wishes of a frail elderly resident, family members frequently complicate the ability of clinicians to honor those wishes. A competent resident has full authority to assert his or her wishes for care, and may even overrule his or her own advance directive. The durable power of attorney document names a health care agent who has authority identical to the patient in terms of all medical decisions, even to the point of terminating life support.

But in many instances there is no durable medical POA document. PA Act 169 (2006) specifies a hierarchy of relatives who are named a health care representative when no one is legally named to be the agent. The representative can make many decisions for the patient but lacks the authority to terminate life support.

The problem comes when other family members disagree with the decisions made by the agent or representative. An ethics committee can assist the clinician and family in understanding who has the authority to make decisions. Furthermore, one advantage of an ethics committee is the availability of unbiased people to facilitate good decisions regarding an individual resident’s care.

POLST is a great tool that is legally recognized in Pennsylvania. An ethics committee can provide energy and awareness to assist in implementing POLST in your facility. Check out the slide decks from the recent PMDA symposium at www.pamda.org for more information.

Ethics committees can promote awareness of the need for legal documents like durable power of attorney for health care. When no such document exists and it is clear that a resident lacks decision-making capacity, an ethics committee can assist the health care agent in understanding his or her role before...
Put your PMDA membership to work at www.pmds.org

by Leon Kraybill, MD, CMD (717) 544-3022; leonkraybill@gmail.com

PMDA members can now gain full access to and benefit from the long term care resources available on the PMDA website, www.pamda.org. As of November, members can log into the website with use of a username and personal password.

PMDA on the Web now offers a wide range of information for LTC providers in Pennsylvania, including clinical updates, dementia, ethics, pharmacy, policy and procedure, downloadable forms and templates, PMDA meetings and newsletters, and many other items.

PMDA member discussion board – The latest member resource went live in November. This is an online place to raise your most frustrating dilemma, share a clinical pearl, raise a philosophical question, propose a new perspective, or share the joys and frustrations of LTC. Check in regularly with the discussion board to connect with your colleagues across Pennsylvania. Instructions for the discussion board login will be provided on the home page of the website. There is an option for you to receive email notification when there is a new discussion item posted. The discussion board is available to PMDA members only.

Other online resources at www.pamda.org include:
- 2012 Annual Symposium power point slides
- Get ideas for starting and running a LTC ethics committee
- LTC forms and templates that others have found useful
- Sample policy and procedure documents
- Classified advertisements – consider a new job by advertising your professional skills or reviewing Pennsylvania LTC openings
- Resources for the older driver
- IDT clinical tools
- Use prepared community lectures, or academic geriatric lectures
- Coming soon—pharmacy page hosted by geriatric pharmacists on medication issues and tools in LTC

New ideas and resources are welcomed to the website. Please send ideas, questions, or problems to the webmaster at leonkraybill@gmail.com.

Welcome New Members

PMDA welcomes the following new member to the Association:

Active Members
Aolufunmilayo Aiyegbo, CRNP
Herbert Bergman, MD
Stacey Brennan, CRNP
Rolanda Coverson, CRNP
Jodi Dobslaw, CRNP
Sabahat Farooq, MD, CMD
Umar Farooq, MD, CMD
Tammi Grumski, CRNP
Gerald Hartle, Jr., CRNP
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Megan Moore, CRNP
Robert Pfoff, MD
Michelle Raymond, CRNP
Gursharan Singh, MD
John Terry, MD
Jennifer Turpen, CRNP
Patricia Volpicelli, CRNP
Kevin Wong, MD

Affiliate Members
Marlene Bannon
Beth Greenberg
Carolyn Hann, RN
Sandra Kenton, RN

Long Term Care Industry Partner
Frank Byrne

Physician-in-Training
Maggie Lee, MD
Recommendations to increase quality of care for frail older adults

by J. Kenneth Brubaker, MD, CMD, c-jbrubake@state.pa.us; (717) 772-2540

One of my responsibilities working at the Pennsylvania Department of Aging (PDA) includes reviewing potential elder abuse and neglect cases. A very common scenario involves frail older adults living at home or in a personal care facility and experiencing a slow decline in their ADLs and weight loss.

Frequently, these declining situations are often indicative of a resident nearing end of life and becoming hospice appropriate. Unfortunately, there is minimal follow up by primary care providers who depend solely upon the caregivers to share the declining medical conditions. Consequently, these residents frequently develop several or more pressure wounds that eventually become infected and the resident is sent to the local emergency room for a medical evaluation.

When emergency room providers observe a frail older adult with multiple pressure wounds, photos are taken, the resident is admitted to the hospital, and a consultation is made with the Older Adult Protective Services.

Unfortunately, what I observe too often in these situations is limited to no regular follow up by the resident’s PCP. These situations become the “perfect storm” for eventual elder abuse/neglect. The home caregiver is often not aware of the numerous services available for assistance in home care, and there is lack of education provided to the caregiver of the increase risks of pressure wounds associated with declining ADLs and weight loss.

Using my experiences evaluating frequent potential elder abuse cases in the PDA, I have listed a number of recommendations that can improve the quality of care and prevent charges of neglect or abuse among frail older adults living at home or in a personal care community.

1. Frail older adults, especially those with significant dementia, are above average risk in experiencing elder abuse/neglect.
2. Weight loss and decline in ADLs is a red flag for future elder abuse/neglect without close provider follow up and appropriate documentation of the declining condition.
3. Lack of caregiver support can lead to elder neglect/abuse.
4. Missing provider appointments by frail older adults is a red flag for potential elder abuse/neglect.
5. Lack of a younger health care advocate for frail declining older adults can lead to neglect/abuse.
6. Slowness in referring a declining frail older adult to community services, hospitalization, and/or nursing home care can lead to elder abuse/neglect.
7. Providers’ failures to clearly document in their notes that residents are nearing end of life and a comfort care discussion occurred with residents and/or health care agents can lead to elder abuse/neglect.
8. Providers’ failures to schedule more frequent follow-up visits with frail adults can lead to potential elder abuse/neglect.
9. Providers cannot depend upon the caregivers to determine the frequency of follow-up care for frail older adults with declining ADLs and weight loss.
10. Provider’s failure to consult the Adult Protective Services, when there is early evidence that the caregiver is unable to provide adequate care for frail older adults, can lead to future charges of elder abuse/neglect.
The 20th annual PMDA Symposium was a success once again, well attended by many long term care professionals. In its 20th year, the symposium focused on increasing quality of care in the long term care facility by improving medication management and transitions of care (slides of all the lectures are available to PMDA members at www.pamda.org ).

Richard Stefanacci DO, MGH, MBA, AGSF, CMD, launched our Friday morning session, as he gave us an excellent lecture with many tips on how to improve medication management in the nursing facility. He described how members of the interdisciplinary team could work together, using tools such as the MDS (Minimum Data Set), Quality Indicators, Internet resources and AMDA clinical practice guidelines to improve management of medications in their facility. He also discussed care transitioning between institutions and noted that medication must be carefully managed in order to prevent the 20 percent incidence of errors that has been shown to occur during these transitions if thorough medication reconciliation is not performed. Dr. Stefanacci revealed some money-saving tips during his lecture. He noted that immunizations and any medications considered related to dialysis by CMS do not need to be covered by the facility during a resident’s Part A stay. The cost of these dialysis medications is considered by CMS to be included in the payment to any dialysis center, he informed us. Dr. Stefanacci encouraged our sharing of this information with our facilities, because he feels it will not only help the bottom line of our facilities but will also demonstrate our value to facility administrators.

Colleen Kayden, RPh, then shared a complicated mix of new medicines arriving on the long term care scene. Colleen shared the New Drug Comparison Rating (NDCR) scale: a 1-5 rating system that clarifies the value of new medicines. In this system, a rating of 5 = important advance, while 1 = important disadvantages. She discussed multiple oral anticoagulants, weighing their risks and benefits as well. She also described the significant risks and benefits of the new anti-platelet agents Ticagrelor (NDCR-4) and Prasugrel (NDCR-4). Expensive fidaxomicin used for Clostridium difficile (NDCR-3), and a new antidepressant Vilazodone (NDCR-2) were also discussed (see the PMDA website for other discussed medications).

Not only did Colleen discuss anticoagulation, but Bill Smucker, MD, CMD, also spoke about anticoagulation in the context of Atrial fibrillation and VTE prophylaxis. He reviewed recent guideline changes and pointed out a risk predictor model for anticoagulants. Of note, he mentioned that the risk of using Aspirin increases significantly in individuals over 80.

Jonathan Evans, MD, MPH, CMD, discussed how, why and when to stop medications in long term care as he wrapped up our session on medication management. He gave useful lists of medications that are frequently the cause of common symptoms experienced by long term care residents. Dr. Evans then gave some interesting case presentations demonstrating the potential harm that can come from prescribing cascades that occur when underlying adverse drug reactions are not recognized.

Kathleen Wilson, PhD, gave a CMS update. She mentioned that CMS would be giving a ruling on the payment of physicians for care plan participation in the nursing facility in the near future. Rodney Myer, JD, then reviewed difficult issues regarding guardianship and end-of-life decision-making. It was noted that the POLST is helpful when individuals have an end stage medical condition, because it can communicate end-of-life preferences.

As the day came to a close, Dave Nace, MD, MPH, CMD, and Ken Brubaker MD, CMD, discussed public policy. Dr. Nace discussed initiatives to reduce antipsychotic use in nursing facilities in the next year, along with the national action plan to prevent health care associated infections. Dr. Brubaker described the coming of Accountable Care Organizations and the success of Evercare as a model for an ACO. Health care information technology regulations and QAPI (Quality Assurance Performance Improvement) were discussed as the day ended.

The Saturday sessions were also well attended as they focused on two types of system improvements for transitions of care, the Interact 2 and POLST. Joseph Ouslander, MD, began the day by giving a thorough overview of the Interact 2. The Interact 2 is a program that is freely obtained from the Internet and gives nursing facilities many tools to improve assessments and communication. He mentioned that Interact 2 continues to evolve, as he described a new tracking system and Excel based calculator that will be available through the website in early January in order to help facilities track nursing facility transfers and look at root cause analysis.

The POLST and evolving developments were then reviewed by Judith Black, MD, MHA. The POLST use and acceptance is becoming more widespread in Pennsylvania. Dr. Nace and Neelofer Sohail, MD, CAQ, CMD, reviewed the POLST’s common problems and pitfalls, and then reviewed solutions for POLST implementation.

Slides from this year’s symposium are available on the PMDA website (www.pamda.org) for use by members and are a valuable resource as you work to educate your medical and nursing staff about important issues in long term care.
QAPI: What is it?

by Karyn P. Leible, MD, CMD; kpleible@gmail.com; (303) 478-6118

Health care reform in many of its provisions refers to providing health care to consumers that is of high quality and lowered cost. Provision 6102 requires an establishment of standards relating to quality assurance and process improvement in long term care. The purpose of the provision is to promote accountability among long term care providers for resident care and resident safety, thus improving quality.

Long term care currently has a federal regulation that requires facilities to monitor quality, F Tag 520 Quality Assessment and Assurance. The regulation states that the facility must meet quarterly to identify issues for further review and potentially development and implementation of plans of action. What is missing from the regulation and the accompanying guideline is the how. Facilities are at various levels when it comes to looking at processes of resident care and resident safety. It is fair to say that there is a wide variation as to how QA&A is currently being done. Many staff in long term care has not had the training needed to look at processes of care rather than specific resident care concerns.

QAPI is the acronym for Quality Assurance and Process Improvement. Quality assurance is the umbrella that covers facility processes, organizational structure and facility procedures that ensure care practices are consistently applied. Process improvement is an ongoing interdisciplinary process that is designed to improve the delivery of services and resident care outcomes.

A focus of the QAPI initiative is to develop resources for staff and facilities to utilize to assist them with their internal review process of resident care and safety. Quality Assurance and Process Improvement starts with identifying five elements needed for the program to be successful.

1. Design and scope
   This element requires all departments within the facility be involved. The program needs to be comprehensive and ongoing. It needs to be sustainable even with staffing and personnel changes. Design of the program should be based on best evidence available for the problem being addressed and what works well in the individual facility. The program should address safety, quality of life and quality of care as well as resident choice and transitions of care within the health care system.

2. Governance and leadership
   In order for any program to succeed, leadership needs to be supportive of the program at all levels. Leadership, including owners, boards and administration staff, needs to make a financial and time commitment to make resident care and resident safety a priority. There needs to be support of staff training time for learning QAPI. There needs to be financial support in order to provide needed resources.

3. Feedback, data monitoring systems and monitoring
   Within this area, there is a wide range of variation in the nursing facilities. Some are very sophisticated and have internal systems established, while others rely on proprietary systems that they have purchased. Part of the QAPI initiative is to establish educational resources to assist homes in development of monitoring systems so that they can gather their own data.

4. Performance Improvement Projects
   This provides the home with an opportunity to review data that has been collected and decide on a project to make an improvement. A team is formed to address an issue by reviewing the data, developing an intervention, implementing the intervention, and collecting the data again. Many will recognize this as being part of a standard approach to process improvement. What is potentially different is including all staff in the process. A home may have more than one process improvement project occurring at a time. For example, there may be one on falls and another on weight loss.

5. Systemic analysis and systemic action
   A problem is not always what it first appears. For example, a resident falls because her call light was not answered timely by the CNA. In drilling down, we learn that the CNA was new and did not know the resident well and was helping another resident. The CNA had not been oriented to the unit when she came on because the nurse who was tasked to orient her had been called away to assist with the transfer of another resident. Root cause analysis can be done in different ways. These are some of the resources that are to be made available to facilities as part of the QAPI initiative.

The medical director plays a role in the success of a home’s development of an effective QAPI program. The facility medical director has two roles in the facility by federal regulation (F Tag 501): 1.) implementation of resident care policies and 2.) coordination of medical care in the facility.

One of the ways to be effective in the role is through involvement in the program that is monitoring resident care and resident safety. The medical director can assist the facility with interpreting the data. He or she can ask the questions that can lead to the development of process improvement projects, for example: “Why does this facility have so many urinary tract infections in the summer?” The medical director is able to assist the facility with identifying a root cause for a problem. The medical director is part of the facility leadership that provides one of the essential elements of the QAPI process.

Dr. Leible lives in Rochester, NY, and is Immediate Past President at AMDA. ■
Promoting influenza vaccination among health care workers: An evidenced-based approach to helping your LTC facility

by Pamela Kinsey, BSN, RN, WCC; pkinsey@itcmail.com; (717) 299-7855

Thousands of deaths, many preventable, occur annually in the U.S. related to influenza symptoms. The influenza vaccination is proven to reduce illness and death. Vaccination of health care workers (HCW) is a critical measure to reduce influenza illness among patients. HCW’s injection is a key measure to protect patients. The campaign should also focus on eliminating the following unsubstantiated beliefs: HCW is in good health and does not require vaccination; good hand washing will prevent the flu; and concern that severe influenza will develop because of vaccination.

Research also revealed that improved rates can be achieved by:
- Providing easy access to the vaccine
- Supporting leadership in a facility
- Developing incentives to obtain the vaccine
- Refreshed annual campaigns

Scheduling a specific day for vaccination and providing education to every employee also helped to improve rates. Translation of evidence into practice assisted in the development of an effective influenza campaign in our facility.

- A team of champions was developed to promote vaccination and implement the campaign.
- The vaccination was offered free of charge.
- Accessibility was a key focus with development of a roaming cart that visited each nursing unit during every shift. The champions manned the cart and gathered the employees together when offering the vaccination. The peer pressure assisted to improve vaccination rates in the facility. The champions promoted the vaccine as a way to protect residents and offered one-to-one education as needed for HCWs.
- Incentives were offered: a coupon for a free employee meal and a competition for a pizza party among the teams and shifts.
- Unvaccinated employees were required to wear a mask during the flu season when providing care to residents. A sticker on the employee identification badge indicated the employee received their vaccination, eliminating the need to wear a mask.
- If an employee chose to refuse the vaccination, they were required to sign a declination letter, that clearly stated they were putting residents, their family and themselves at risk for death by choosing not to accept the vaccination.

The influenza campaign launched in September 2011 and resulted in more than 98 percent of the 700-plus employees in the facility accepting vaccination.

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a crisis that requires decision making occurs.

Your facility’s policies may not be up to date with respect to Act 169 and POLST. The ethics committee should review and help formulate policies that provide a framework to enable proper end-of-life decision making. Additionally, policies regarding other ethical issues should be reviewed by the ethics committee.

Indeed, the role of the ethics committee is not restricted to end-of-life care. Other issues include prevention of abuse, sexual behavior among residents, supporting the rights of LGBT residents, and respecting various religious traditions within your building.

Who should be on the committee? The administrator and medical director are essential. An attorney would be helpful but is rarely available. Representatives from nursing, a chaplain, a social worker, and retired legal or medical professionals who live nearby or in your CCRC are ideal members.

Nursing staff, attending physicians and nurse practitioners all need to be aware of how to contact a committee member with a concern. Educational programs should be sponsored by the committee at least annually. The committee should meet at least quarterly to enable the members to gain familiarity with their role in ethical decision making before a situation arises that requires an urgent meeting.

Further resources are found in the slide deck from the 2012 AMDA Symposium (#C15), and on our own website at www.pamd.org. For a modest fee, AMDA sells a toolkit to provide all you need to establish an ethics committee in your facility.

This marks the final printed version of PMDA News. A new e-newsletter format will be published in 2013.