

CHANGE PACKAGE: Actions to Prevent All Causes of Harm in Nursing Homes



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Reliable Implementation of Timely, Quality Care Practices

The following care practices were described by high-performing nursing homes to prevent, detect, and mitigate harm events related to medication, resident care, infections, abuse, and neglect. The care practices are formatted with square bullets so that you can use this resource as an assessment of your practices and to assist in identifying actions you want to implement or discuss with your team.

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

EVENTS RELATED TO MEDICATION

Prevent medication-induced delirium or other changes in medical condition

Foundational and Ongoing Education Topics to Consider

- Educate staff on delirium, dementia, and depression – causes, risk factors, and symptoms, including behavioral expressions/changes, treatment, and prevention. Include a focus on distinguishing between these conditions.
- Educate nursing assistants on symptoms to watch for when a resident is taking a medication that may put them at risk for delirium.
- Educate nurses on the importance of assessing for resident reactions/response to new or changed medication. “For any resident changes, think if/how medications may have played a role.”

Pre-Admission Practices

- Review medications for appropriateness.
- Review medications with discharging physician and facility attending physician/practitioner, as needed.
- Review medications with consulting pharmacist, as needed.

EVENTS RELATED TO MEDICATION

Admission Practices

- Establish a process where the resident's medications are reviewed and reconciled, looking for indications/diagnoses, dosing, polypharmacy, and medications that may cause delirium (e.g., opiates or psychotropic medications) or other negative side effects. Follow up with an appropriate provider if there are questions or if information is missing.
- Involve the resident and family in the medication reconciliation process.
 - o Talk to resident and family to better understand family history, perceptions of medications, and preferences in order to help inform medication decisions.
- Provide education on and discuss the medications that the resident is taking with the resident and family so that they are aware of benefits and risks.
- Establish a system that alerts nursing staff on specific adverse side effects for medications (e.g., EHR functionality that highlights side effects and drug interactions or other references available through pharmacy consultation).
- At daily stand up/interdisciplinary team (IDT) meeting, review new resident's admission medications and potential side effects to monitor and report.
- Add 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 they worked in order to ensure they are aware of changes).
- Nurses reconcile medications on each shift for the first 24 hours (reconcile admission orders, transfer orders, discharge orders, and the medication administration record).
- Use the Beers criteria to identify potential inappropriate medication use in older adults.

Ongoing Care Practices and Monitoring

- Have a process in place where prescribers can flag if a medication change has been discussed with resident/family/caregivers or if staff should have this discussion prior to starting medication, or, if the medication is urgent, an expectation that the discussion will occur within 24 hours.
- At daily stand up/IDT meeting, review residents' medication changes and specific monitoring needed.
- Add 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).
- Establish a process where the resident's chart is flagged for any new or changed medications so that the nurse can assess the resident's response to the medication for at least three days after the change (watching for any changes in condition and side effects including allergic reactions, thrush, hypoglycemia, hypotension, etc.).
- Avoid/eliminate the use of PRN (as needed) psychotropic medications.
- For medications such as antipsychotics and other psychoactive agents, establish process for IDT to discuss and implement gradual dose reduction when appropriate, considering non pharmacologic interventions.
- Establish a process for ongoing medication review that assesses need, impact, side effects, discrepancies, and determines appropriateness of the medication. Involve the pharmacist.
 - o Review all medications monthly and discontinue any that do not have a clear indication.
 - o Report pharmacist identified irregularities in dispensing and administration of drugs, and recommendations, to key team members, including the attending physician and director of nursing.
- Establish a process for timely review of and follow up on pharmacist recommendations. Involve the medical director for support in this process.
 - o Bring medication discrepancies or irregularities that need immediate attention to the director of nursing.
 - o Assign responsibility for following up on the pharmacist identified errors, irregularities, and discrepancies, and documenting actions taken.

- o Review the monthly pharmacist report, submitted to the administrator, with clinicians and direct care staff to support ongoing learning and to identify if any medication related policies need updating or development.
- Establish a process for timely review of and follow up on pharmacist recommendations. Involve the medical director for support in this process.
- Establish a process to evaluate/assess for delirium, distinguishing it from other conditions such as dementia or depression.
- Create transparency through benchmarking/trending by clinician (e.g., number of medications per resident, number of residents on antipsychotics, or other psychotropic medications).

Resources to Consider

- American Geriatrics Society Beers Criteria for Potentially Inappropriate Use of Drugs in Older Adults - <https://www.americangeriatrics.org/publications-tools> and click on Updated AGS Beers Criteria.
- CMS, Hand in Hand Dementia Training (includes information on delirium) - <https://surveyortraining.cms.hhs.gov/pubs/HandinHand.aspx>
- National Partnership to Improve Dementia Care in Nursing Homes, resources for professionals - <https://nhqualitycampaign.org/professionalDementia.aspx>
- National Institute on Aging, Alzheimer's and dementia resources for professionals (includes educational materials on delirium) - <https://www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals>
- ConsultGeri, education and training resources on Delirium: A Patient and Family Centered Care Approach - <https://consultgeri.org/education-training/e-learning-resources/delirium-patient-and-family-centered-care-approach>
- The Society for Post-Acute and Long-Term Care Medicine, Quality Prescribing - <https://paltc.org/quality-prescribing>
- CMS, Adverse Drug Event Trigger Tool - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/Adverse-Drug-Event-Trigger-Tool.pdf>
- CMS, LTC Survey Pathway, Dementia Care - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
- CMS, LTC Survey Pathway, Behavioral and Emotional Status - <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
- See [Appendix D](#) for suggestions on team members in your organization to include in quality improvement efforts for this topic.

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).

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.

Prevent falls/falls with injuries or other trauma with injury secondary to effects of medication

See sections titled "[Prevent fall or other trauma with injury related to resident care](#)" and "[Prevent medication-induced delirium or other changes in medical condition.](#)"

Prevent constipation, obstipation, and ileus related to medication

Foundational and Ongoing Education Topics to Consider

- Educate nurses about medications that can lead to constipation, obstipation, and ileus, as well as signs and symptoms, management and prevention of constipation, obstipation, and ileus.
- Educate nursing assistants on symptoms to watch for and monitoring of bowel movements (e.g., watch for resident passing fewer stools than is their normal, hard stools, straining to have bowel movements, or feeling of blockage in rectum that prevents bowel movements).

Pre-Admission Practices

- Review medications that could lead to constipation, obstipation, or ileus.
- Review with resident and family any significant history or concerns related to bowel habits.

Admission Practices

- Assess resident's bowel habits/schedule on admission (three-day observation/diary, and then evaluate the need to continue the diary to establish elimination patterns).
- Discuss bowel routines with resident to determine if specific foods, fluids, or medications were used to support regular bowel movement.
- Discuss and determine the plan of care with the resident (and family as applicable) so that they know what to expect and can help monitor consistent implementation of the plan of care.

Ongoing Care Practices and Monitoring

- Monitor and document resident's bowel movements and any concerns.
- Establish alerts/flags and follow up protocol if a person has not had a bowel movement in a certain time period (e.g., three days or per the resident's normal bowel routine).
- Assess need for scheduled laxatives or stool softeners for residents taking medications that can cause changes in bowel patterns (e.g., antacids, antidepressants, some blood pressure medicines, cold medicines (antihistamines), calcium and iron supplements, or narcotic pain medicines).
- Ensure residents are up and moving about as much as they are able.
- Provide food choices to promote regular bowel movements (e.g., fiber, fruits, and vegetables).
- Offer residents their preferred food choices and beverages during activities.
- Provide residents with fluids at meals and throughout the day (if not contraindicated).
 - Consider providing 'hydration stations' (e.g., water dispensers that allow residents, families, or staff to obtain water at any time).

Resources to Consider

- Mayo Clinic, Constipation - <https://www.mayoclinic.org/diseases-conditions/constipation/symptoms-causes/syc-20354253>
- UCSF Health, Constipation - <https://www.ucsfhealth.org/education/constipation/>
- Statis SC and Jorge T., Update on the management of constipation in the elderly: new treatment options, Clin Interv Aging. 2010; 5: 163–171. - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920196/>
- Beers Criteria for Potentially Inappropriate Medication Use in Older Adults - <https://geriatricsonline.org/ProductAbstract/american-geriatrics-society-updated-beers-criteria-for-potentially-inappropriate-medication-use-in-older-adults/CL001>
- See [Appendix D](#) for suggestions on team members in your organization to include in quality improvement efforts for this topic.