Daily Strategies To Use During Your **Nursing Home** Stand-Up Meetings

The following Health Quality Innovation Network resource is a 9-week education series tailored for nursing home stand-up meetings, aimed at decreasing preventable emergency room (ED) visits and hospital readmissions.

Each week of this resource contains five short, concentrated evidence-based talking points that can easily be included in daily stand-up meetings to increase staff knowledge on relevant topics like effective communication, adverse drug events and infection prevention. The program is designed to empower caregivers with practical knowledge to foster a safer environment.

This material was prepared by Health Quality Innovators (HQI), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 112SOW/HQI/QIN-QIO-0758-04/02/24

HQIN
Health Quality Innovation Network

Week 1: Pneumonia

Monday

Pneumonia can lead to emergency department visits and rehospitalization. If you prevent pneumonia, you can prevent going to the hospital.

Monitor for early signs such as shortness of breath, coughing that gets worse, change in mucus, fever and chest pain. If treated early, many residents can remain in the nursing home and avoid hospitalization. **Review Friday to Sunday 24-hour reports to identify residents with changes in conditions that could indicate pneumonia.**

Tuesday

The pneumonia vaccine is the single most effective way to reduce the incidence of pneumonia. **Review your immunization process:**

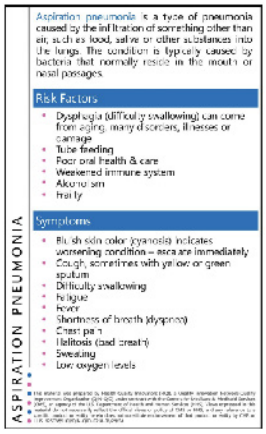
- Are all residents assessed upon admission for immunization status including pneumonia vaccine status, and are they offered the vaccination as appropriate?
- Is the vaccine provided in a timely manner after consent is obtained?
- Is there an immunization tracking system that includes resident pneumonia vaccines? If yes, is there a schedule in place to audit the tracking system?

Did you know the Centers for Disease Control and Prevention (CDC) has a mobile app (and web version) to help vaccination providers quickly and easily determine which pneumococcal vaccine is needed and when? Find out more about PneumoRecs VaxAdvisor Mobile App for Vaccine Providers.

Wednesday

Pneumonia can be caused by aspiration.

- Are all residents monitored for aspiration risk and referred to speech therapy for an evaluation if risk is identified?
- Are there residents who are an aspiration risk and need to be referred?
- Is there education and competency available on precautions, signs and symptoms of aspiration? **Provide your staff a quick reference resource with HQIN's** Aspiration Pneumonia Pocket Card. **Download the PDF, print it, cut out the cards (there are three to a page) and distribute them to staff.**



Thursday

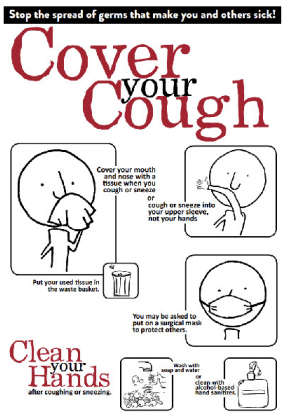
Did you know providing daily oral care can prevent bacteria from accumulating and will decrease risk of pneumonia if aspiration occurs? **Assign staff to verify that all residents have a toothbrush and toothpaste as appropriate.** Are residents care planned as applicable for assistance with oral care?

Friday

To prevent the spread of respiratory infection, remind residents and staff to practice respiratory hygiene and cough etiquette. Is there signage posted to remind residents, visitors and staff about cough etiquette?

Click the images or links below to download signage to hang in your facility as a reminder for everyone to cover their cough.

Cover Your Cough Sign (Centers for Disease Control and Prevention)



Cover Your Cough (Association for Professionals in Infection Control and Epidemiology)

Week 2: Urinary Tract Infections (UTIs)

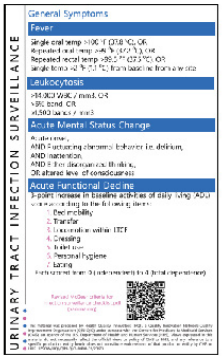
Monday

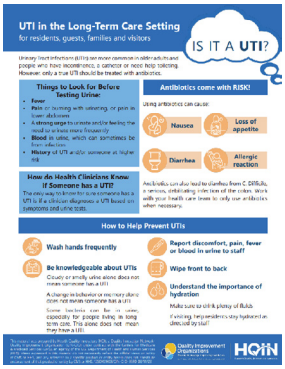
A suspected UTI can lead to a resident being transferred to the hospital. What does staff do if they suspect a resident has a UTI, or if the resident or family member tells you they suspect a UTI?

How does your clinical and physician staff know which criteria (McGeer, Loeb, NHSN) the facility follows? Has education been provided on this?

Download the two resources below to guide nursing staff in the initial evaluation of a possible UTI. **Review the weekend 24-hour reports for suspected UTIs.**

Urinary Tract Infection Surveillance Pocket Card





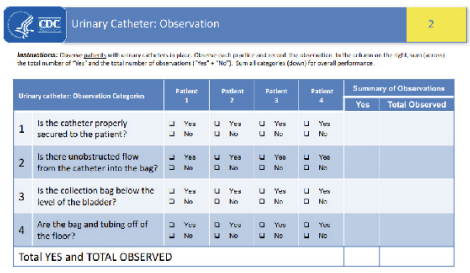
UTI in Long-Term Care Setting: Residents, Guests, Families, Visitors

Tuesday

As you are rounding, observe the following for residents with a urinary catheter and notify nursing as appropriate for any needed interventions. Perform hand hygiene before each and every manipulation of the catheter device or site. During inspection, look to make sure:

1. The catheter tubing is unobstructed and not twisted, kinked, or looped,
2. The urine collection bag is BELOW the level of the bladder. The catheter bag should never touch the floor,
3. The catheter is secured to the resident if mobile, and
4. The drainage bag is covered with a dignity bag. Empty the collection bag regularly and prior to transport.

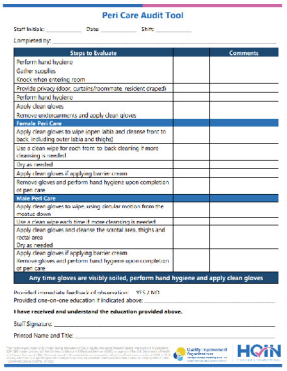
Observe residents with urinary catheters. Use the urinary catheter observational tool to record your findings.



Wednesday

When is the last time you completed CNA observation rounds or competencies for providing peri care to residents?

Performing peri care the proper way can reduce the likelihood of a UTI. It is recommended to audit all new CNAs upon hire and annually. **Share this** Peri Care Audit Tool **with your clinical staff and schedule peri care audits.**


Peri Care Audit Tool

Start time/date: _____ Date: _____ Shift: _____

Completed by: _____

Steps to Evaluate		Comments
Perform hand hygiene		
Gather supplies		
Knock when entering room		
Provide privacy (door, curtains/roommate, resident draped)		
Perform hand hygiene		
Apply clean gloves		
Remove underpads/briefs and apply clean gloves		
Female Peri Care		
Apply clean gloves to wipe upper, labia and crease front to back, including outer labia and thighs		
Use a clean wipe for each front to back cleaning, if more cleansing is needed		
Dry as needed		
Apply clean gloves if applying barrier cream		
Remove gloves and perform hand hygiene upon completion of peri care		
Male Peri Care		
Apply clean gloves to wipe, using decluttering motion from the meatus down		
Use a clean wipe each time if more cleansing is needed		
Apply clean gloves and cleanse the scrotal sac, thighs and torso area		
Dry as needed		
Apply clean gloves if applying barrier cream		
Remove gloves and perform hand hygiene upon completion of peri care		

Any time gloves are visibly soiled, perform hand hygiene and apply clean gloves

Provided immediate feedback of observation: YES / NO

Provided one-on-one education if indicated above:

I have received and understand the education provided above.

Staff Signature: _____

Printed Name and Title: _____

Quality Improvement Organization Support Center for Illinois

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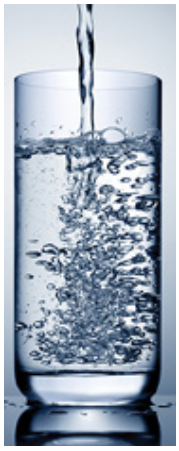
Thursday



Take a close look at hydration. Are residents hydrated? What process is in place to offer residents fluids with each contact?

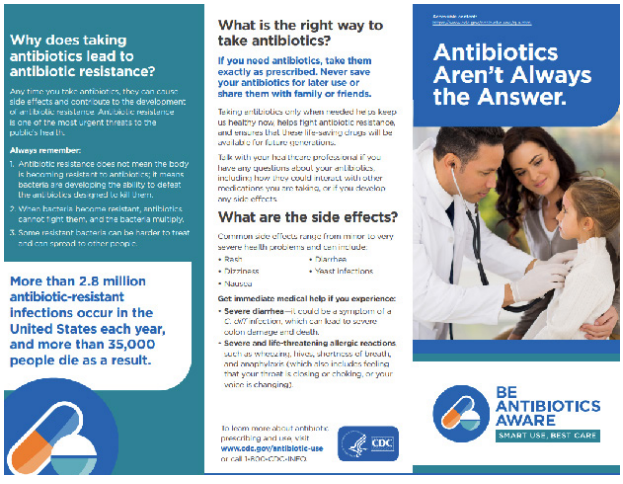
Remind direct care staff to offer fluids frequently and consider a "hydration station" and/or offering something to drink at resident activities and gatherings. Jell-O and popsicles are a great way to offer additional hydration.

Discuss with the team how additional hydration can be provided to the residents.

Friday

Are the residents and families involved in UTI prevention? Providing education about the signs and symptoms of a UTI and the risks of antibiotic use is very important. Families have good ideas so be sure to ask them to help with providing hydration when they visit.

Download the Centers for Disease Control and Prevention's (CDC) Antibiotics Aren't Always the Right Answer resource, print it and make it available at the nurse station for residents and family members.



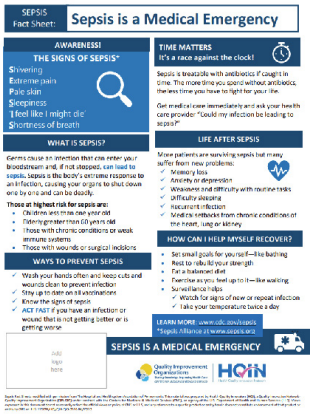
Week 3: Sepsis

Monday

Sepsis is a medical emergency!

Review any new admissions over the weekend for sepsis risk. Talk to staff about the importance of communicating changes in condition early. Review the Stop and Watch tool and SBAR tools for communicating.

Share the Sepsis is a Medical Emergency Sepsis Fact Sheet **with your team and post for others to reference.**


SEPSIS Fact Sheet: Sepsis is a Medical Emergency

AWARENESS!

THE SIGNS OF SEPSIS*

Shivering
Extreme pain
Pale skin
Sleepiness
I feel like I might die
Shortness of breath

WHAT IS SEPSIS?

Germs cause an infection that can enter your bloodstream and, if not stopped, can lead to sepsis. Sepsis is the body's extreme response to an infection, causing your organs to shut down one by one and can be deadly.

Those at highest risk for sepsis are:

- Children are those under one year old
- Elderly greater than 65 years old
- Those with chronic conditions or weak immune systems
- Those with wounds or surgical incisions

WAYS TO PREVENT SEPSIS

- ✓ Wash your hands often and keep cuts and wounds clean to prevent infection
- ✓ Stay up to date on all vaccinations
- ✓ Know the signs of sepsis
- ✓ ACT FAST if you have an infection or wound that is not getting better or is getting worse

TIME MATTERS

It's a race against the clock!

Sepsis is treatable with antibiotics if caught in time. The more time you spend without antibiotics, the less time you have to fight for your life.

Get medical care immediately and ask your health care provider "Could my infection be leading to sepsis?"

LIFE AFTER SEPSIS

More patients are surviving sepsis but many suffer from new problems:

- ✓ Memory loss
- ✓ Anxiety or depression
- ✓ Weakness and difficulty with routine tasks
- ✓ Difficulty sleeping
- ✓ Recurrent infection
- ✓ Medical setbacks from chronic conditions of the heart, lung or kidney

HOW CAN I HELP MYSELF RECOVER?

- Set small goals for yourself—like bathing
- Rest to rebuild your strength
- Eat a balanced diet
- Exercise as you feel up to it—like walking
- Surveillance helps
  - ✓ Watch for signs of new or repeat infection
  - ✓ Take your temperature twice a day

LEARN MORE www.cdc.gov/sepsis
*Sepsis Alliance at www.sepsis.org

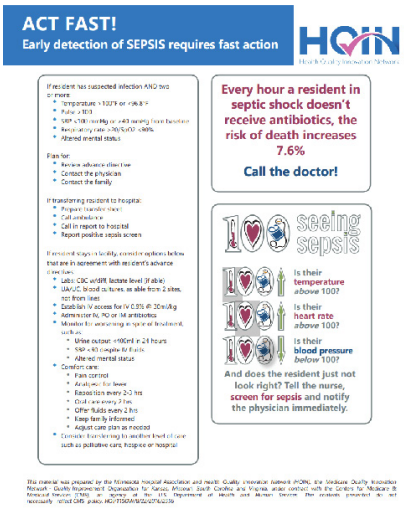
SEPSIS IS A MEDICAL EMERGENCY

Quality Improvement Organizations HQIN

Tuesday

Know the signs of Sepsis. Act Fast! Early detection of sepsis requires fast action!

Act Fast! Early Detection of Sepsis Requires Fast Action


ACT FAST!
Early detection of SEPSIS requires fast action

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If resident has suspected infection AND two or more

- Temperature >102°F or <96.8°F
- Pulse >90
- SBP <100 mm Hg or >40 mmHg from baseline
- Respiratory rate >20/min or <6/min
- Altered mental status

Plans for:

- Review advance directive
- Contact the physician
- Contact the family

If transferring resident to hospital:

- Prepare transfer sheet
- Call ambulance
- Call in report to hospital
- Report positive sepsis screen

If resident stays in facility, consider options below that are in agreement with resident's advance directives:

- Labs: CBC w/diff, lactate level (if able), UA/UC, blood cultures, as able from 2 sites, not from lines
- Crystalloid IV access for IV 0.9% @ 30 mL/kg
- Administer IV, PO or IM antibiotics
- Monitor for worsening or signs of treatment, such as:
  - Urine output: <400 ml in 24 hours
  - SBP <90 (maybe for frail)
  - Altered mental status
- Comfort care:
  - Pain control
  - Analgesic for fever
  - Reposition every 2-3 hrs
  - Oral care every 2 hrs
  - Offer fluids every 2 hrs
  - Keep family informed
  - Adjust care plan as needed
- Consider transferring to another level of care such as palliative care, hospice or hospital

Every hour a resident in septic shock doesn't receive antibiotics, the risk of death increases 7.6%

Call the doctor!

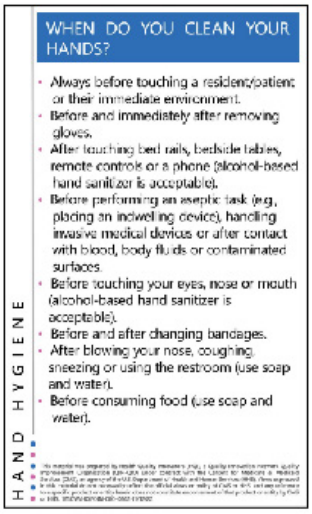
seeing sepsis

Is their temperature above 100?

Is their heart rate above 100?

Is their blood pressure below 100?

And does the resident just not look right? Tell the nurse, screen for sepsis and notify the physician immediately.


WHEN DO YOU CLEAN YOUR HANDS?

- Always before touching a resident/patient or their immediate environment.
- Before and immediately after removing gloves.
- After touching bed rails, bedside tables, remote controls or a phone (alcohol-based hand sanitizer is acceptable).
- Before performing an aseptic task (e.g., placing an indwelling device), handling invasive medical devices or after contact with blood, body fluids or contaminated surfaces.
- Before touching your eyes, nose or mouth (alcohol-based hand sanitizer is acceptable).
- Before and after changing bandages.
- After blowing your nose, coughing, sneezing or using the restroom (use soap and water).
- Before consuming food (use soap and water).

HAND HYGIENE

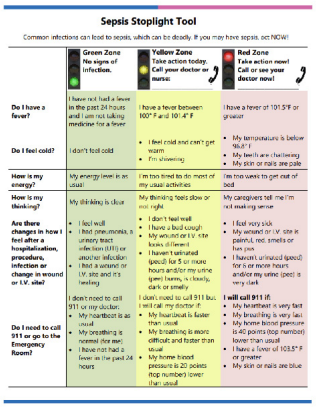
Sepsis Pocket Card

Review the Act Fast! Early Detection of Sepsis Requires Fast Action fact sheet on early detection and Sepsis Pocket Card with your staff and then post where staff can see and reference them.

Wednesday

Common infections can lead to sepsis. If you are discharging a resident to their home, establish a process to provide education on sepsis by providing the Sepsis Stoplight Tool at discharge for residents who have had sepsis or may be at risk of sepsis.

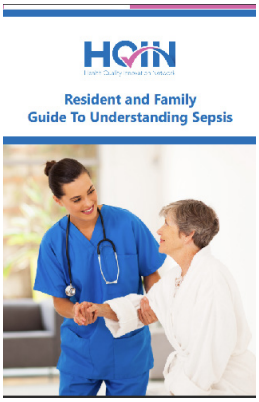
Also, **share the tool** with residents and their families to help them identify what to do if they recognize any signs of sepsis.


Sepsis Stoplight Tool

Common infections can lead to sepsis, which can be deadly. If you may have sepsis, act NOW!

	Green Zone No signs of infection.	Yellow Zone Take action today. Call your doctor or nurse:	Red Zone Take action now! Call or see your doctor now!
Do I have a fever?	I have not had a fever in the past 24 hours and I am not taking medicine for a fever	I have a fever between 100°F and 101.4°F	I have a fever of 101.5°F or greater
Do I feel cold?	I don't feel cold	• I feel cold and can't get warm • I'm shivering	• My temperature is below 95.0°F • My teeth are chattering • My skin or nails are pale
How is my energy?	My energy level is as usual	I'm too tired to do most of my usual activities	I'm too weak to get out of bed
How is my thinking?	My thinking is clear	My thinking feels slow or not right	My caregivers tell me I'm not making sense
Are there changes in how I feel after a hospitalization, procedure, infection or change in wound or I.V. site?	• I feel well • I had pneumonia, a urinary tract infection (UTI) or another infection • I had a wound or I.V. site and it's healing	• I don't feel well • I have a bad cough • My wound or I.V. site looks different • I haven't urinated (peed) for 5 or more hours and/or my urine (pee) looks, or smells, dark or smelly	• I feel very sick • My wound or I.V. site is pain/L red, smells or has pus • I haven't urinated (peed) for 6 or more hours and/or my urine (pee) is very dark
Do I need to call 911 or go to the Emergency Room?	I don't need to call 911 or my doctor. • My heartbeat is as usual • My breathing is normal for me • I have not had a fever in the past 24 hours	I don't need to call 911 but I will call my doctor if: • My heartbeat is faster than usual • My breathing is more difficult and faster than usual • My home blood pressure is 20 points (top number) lower than usual	**I will call 911 if:** • My heartbeat is very fast • My breathing is very fast • My home blood pressure is 40 points (top number) lower than usual • I have a fever of 103.5°F or greater • My skin or nails are blue

Thursday



Educate residents and families on sepsis.

Education can be provided upon admission, with change of condition, discharge, during care plan meetings, and during resident and family council meetings.

Use the Resident and Family Guide to Understanding Sepsis to frame your conversation and provide a copy for them.

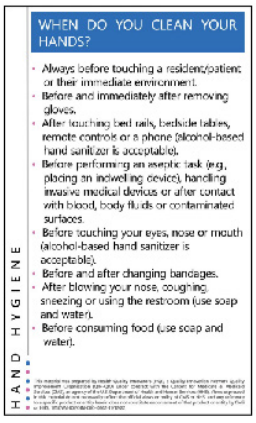
Friday

Share with your staff the importance of hand hygiene to prevent the spread of infections: The Centers for Disease Control and Prevention (CDC) recommends using "ABHR with 60-95% alcohol in healthcare settings.

Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water."

Ask what is the process to replenish your hand sanitizer? Do you have adequate hand sanitizer throughout our facility?

Print and share the Hand Hygiene Pocket Card (shown here) with staff members. Hand hygiene observation rounds are an excellent way to conduct hand hygiene audits.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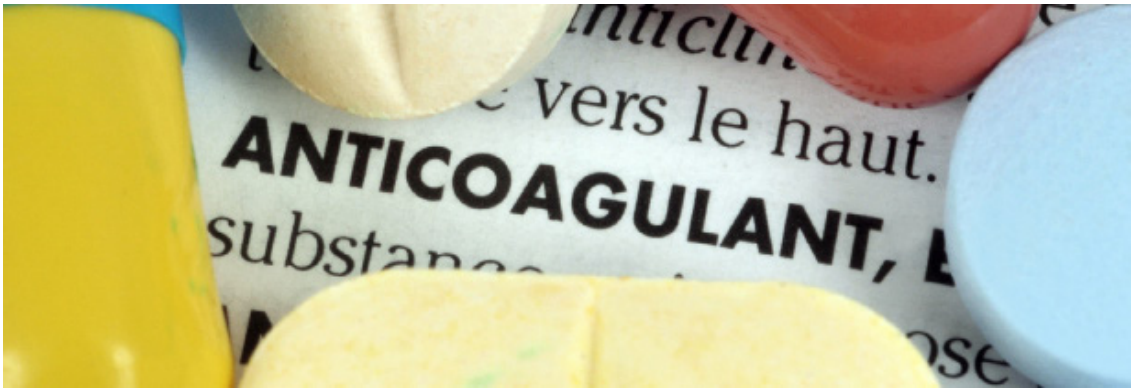
- Before performing an aseptic task (eg, placing an indwelling device), handling invasive medical devices or after contact with blood, body fluids or contaminated surfaces.
- Before touching your eyes, nose or mouth (alcohol-based hand sanitizer is acceptable).
- Before and after changing bandages.
- After blowing your nose, coughing, sneezing or using the restroom (use soap and water).
- Before consuming food (use soap and water).

HAND HYGIENE

Assign a staff member to conduct hand hygiene audits over the weekend. Any staff member can conduct observation rounds (i.e. manager on duty, nursing supervisor) using the Hand Hygiene Competency Validation – SPICE Tool.

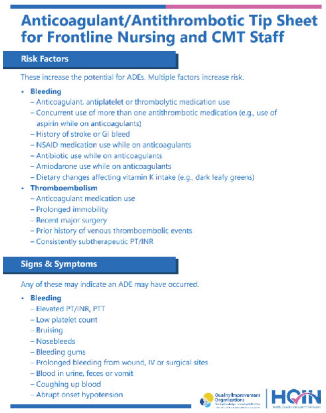


Week 4: Adverse Drug Events - Anticoagulants

Monday

An adverse drug event (ADE) is harm that results from medication use. These events can be due to allergic reactions, side effects, overmedication and medication errors. Anticoagulant medications are necessary for the treatment of some conditions but are also a leading cause of ADEs resulting in ER visits or hospitalization. **Review ADE risk factors and sign/symptoms on this** Anticoagulant Antithrombotic Tip Sheet.

Also, review the Centers for Disease Control and Prevention's (CDC) Adverse Drug Events in Adults **for more safety information.**


Anticoagulant/Antithrombotic Tip Sheet for Frontline Nursing and CMT Staff

Risk Factors

These increase the potential for ADEs. Multiple factors increase risk.

- Bleeding
  - Anticoagulant, antiplatelet or thrombolytic medication use
  - Concurrent use of more than one antithrombotic medication (e.g., use of aspirin while on anticoagulants)
  - History of stroke or GI bleed
  - NSAID medication use while on anticoagulants
  - Antibiotic use while on anticoagulants
  - Amiodarone use while on anticoagulants
  - Dietary changes affecting vitamin K intake (e.g., dark leafy greens)
- Thromboembolism
  - Anticoagulant medication use
  - Prolonged immobility
  - Recent major surgery
  - Prior history of venous thromboembolic events
  - Consistently subtherapeutic PT/INR

Signs & Symptoms

Any of these may indicate an ADE may have occurred.

- Bleeding
  - Elevated PT/INR, PTT
  - Low platelet count
  - Bruising
  - Nosebleeds
  - Bleeding gums
  - Prolonged bleeding from wound, IV or surgical sites
  - Blood in urine, feces or vomit
  - Coughing up blood
  - Abrupt onset hypotension

Tuesday

How do you know who is at risk for ADEs related to anticoagulants? Are new orders or changes to orders for anticoagulant medication use included in hand-off reports? Are abnormal lab results included in hand-off reports? Do the staff providing care review resident care plans related to risks due to anticoagulant medication use?

Consider reviewing new resident admissions anticoagulant medications and potential or observed side effects at stand-up meetings.

Wednesday

Are residents and families educated about anticoagulant use?

Knowledge of risk factors, signs and symptoms of ADEs, and the best ways to stay safe can prevent ADEs and assist with early identification.

Review your policy for medication education. Blood Thinner Pills: Your Guide to Using Them Safely **provides resources for educating residents and families.**

Thursday

Assessment and monitoring play a big part in preventing and identifying ADEs. Residents should be assessed regularly for bruising, bleeding, fall risk and new pain. Lab work must also be ordered, completed and reordered regularly.

Discuss the methods your facility uses to ensure assessment and monitoring.

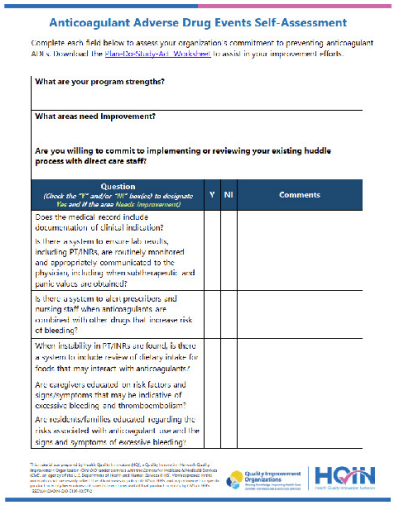
Does the physician or pharmacist use standardized protocols to monitor and adjust medication doses? Are dosages adjusted with weight loss or gain? Are medications reviewed for interactions when new medications are ordered?

Friday

Evaluating your facility's anticoagulant program can assist you with identifying and addressing opportunities for improvement.

This Anticoagulant Adverse Drug Events Self-Assessment provides a checklist for anticoagulant programs.

Discuss the questions as a team and use the Plan-Do-Study-Act Worksheet to work toward improvements.



Anticoagulant Adverse Drug Events Self-Assessment

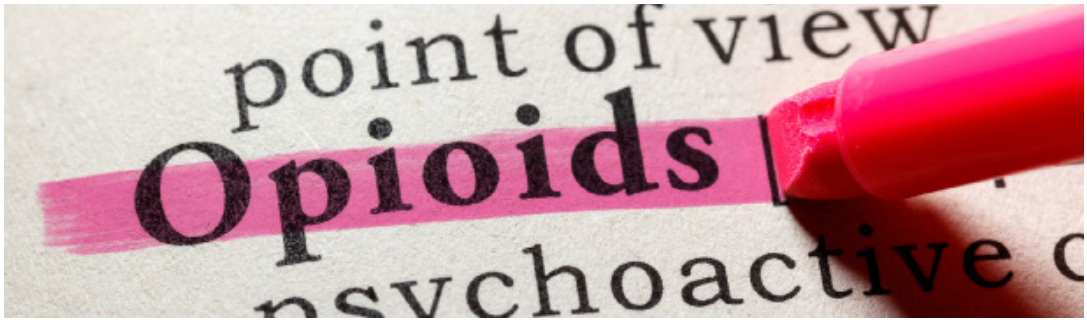
Complete each field below to assess your organization's commitment to preventing anticoagulant ADEs. Download the Plan-Do-Study-Act Worksheet to assist in your improvement efforts.

What are your program strengths?

What areas need improvement?

Are you willing to commit to implementing or reviewing your existing huddle process with direct care staff?

Question (Check the "Y" and/or "NI" box(es) to designate Yes and if the area Needs Improvement)	Y	NI	Comments
Does the medical record include documentation of clinical indication?			
Is there a system to ensure lab results, including PT/INRs, are routinely monitored and appropriately communicated to the physician, including when valid/expected and panic values are obtained?			
Is there a system to alert prescribers and nursing staff when anticoagulants are combined with other drugs that increase risk of bleeding?			
When instability in PT/INRs are found, is there a system to include review of dietary intake for foods that may interact with anticoagulants?			
Are caregivers educated on risk factors and signs/symptoms that may be indicative of excessive bleeding and thromboembolism?			
Are residents/families educated regarding the risks associated with anticoagulant use and the signs and symptoms of excessive bleeding?			

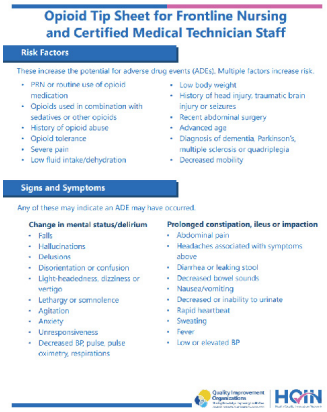


Week 5: Adverse Drug Events - Opioids

Monday

Adverse drug events are commonly experienced by people taking opioids as well as anticoagulants. Like anticoagulants, you will want to ensure staff caring for residents know which residents are at risk and what risk factors and sign/symptoms of adverse events may be.

Discuss opioid risk factors, adverse event signs/symptoms and interventions using the Opioid Tip Sheet for Frontline Nursing and CMT Staff.


Opioid Tip Sheet for Frontline Nursing and Certified Medical Technician Staff

Risk Factors

These increase the potential for adverse drug events (ADEs). Multiple factors increase risk.

- PRN or routine use of opioid medication
- Opioids used in combination with sedatives or other opioids
- History of opioid abuse
- Opioid tolerance
- Severe pain
- Low fluid intake/dehydration
- Low body weight
- History of head injury, traumatic brain injury or seizures
- Recent abdominal surgery
- Advanced age
- Diagnosis of dementia, Parkinson's, multiple sclerosis or quadriplegia
- Decreased mobility

Signs and Symptoms

Any of these may indicate an ADE may have occurred.

Change in mental status/delirium

- Falls
- Hallucinations
- Delusions
- Disorientation or confusion
- Light-headedness, dizziness or vertigo
- Lethargy or somnolence
- Agitation
- Anxiety
- Unresponsiveness
- Decreased BP, pulse, pulse oximetry, respirations

Prolonged constipation, ileus or impaction

- Abdominal pain
- Headaches associated with symptoms above
- Diarrhea or leaking stool
- Decreased bowel sounds
- Nausea/vomiting
- Decreased or inability to urinate
- Rapid heartbeat
- Sweating
- Fever
- Low or elevated BP

Tuesday

Using non-medication pain relief methods can decrease the need for opioids. **Communicating with residents and families** will help find the most effective pain relief methods for each patient. Sometimes facilities use methods like applying heat/cold, massage, ultrasound, or stretching exercises to help ease pain.

Remember to evaluate things like positioning, bed choice and seating choice when you are working to reduce pain.

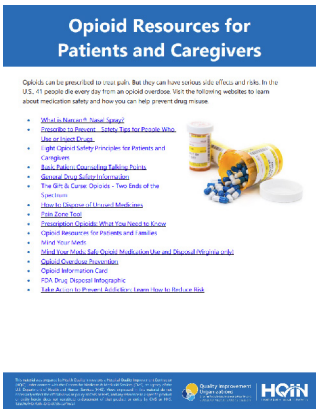
What interventions does your facility use regularly? Can you think of non-medication pain relief methods your facility does not use that may be helpful?

Wednesday

Are residents and families educated about opioid use?

Knowledge of risk factors, signs and symptoms of adverse drug events, and the best ways to stay safe can prevent them and assist with early identification.

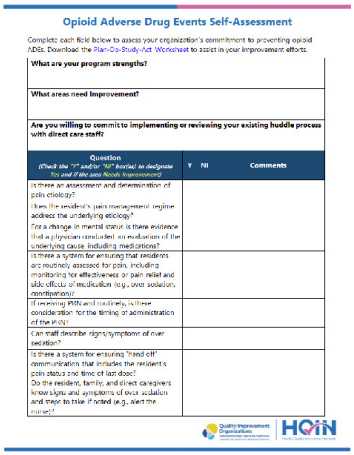
Review your policy for medication education and explore Opioid Resources for Patients and Caregivers.

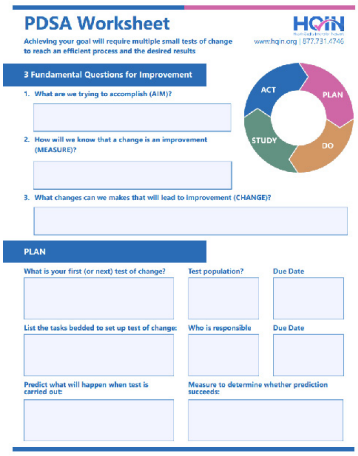


Thursday

Opioids can be useful for controlling pain, but it is important to remember they carry a high risk for adverse events.

Review the Opioid Adverse Drug Events Self-Assessment **with your team.**



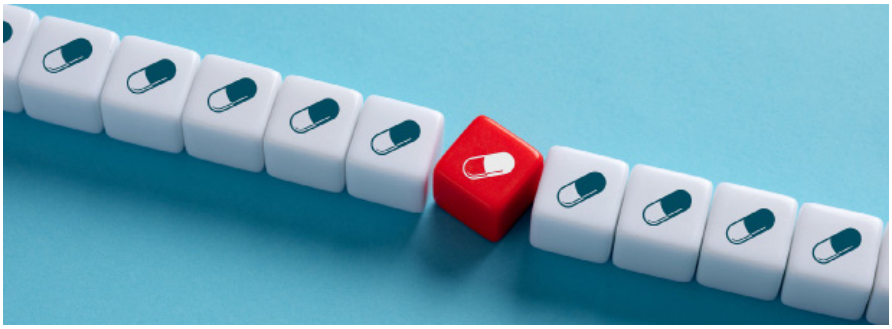


Use the Plan-Do-Study-Act Worksheet **to work toward improvements.**

Friday

Narcan (Naloxone) is a medication used to reverse the effects of opioids. It is often discussed for treatment of overdose with illicit drugs but is often needed for people who are prescribed opioids. Every nursing home should have a policy for Narcan use.

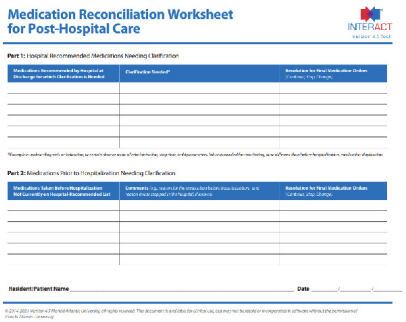
Review your facility's policy with staff. Can staff identify where Narcan is kept and when it should be given? Post the Opioid Information Card **to educate residents and caregivers.**



Week 6: Medication Reconciliation

Monday

If a resident's medication orders reflect the wrong medication, the wrong dose, the wrong time, or the wrong route, adverse drug events are likely. We prevent this by reconciling their medications on admission and with any changes. **Review which staff reconciles medication on admission. Discuss with the team the policy for admission medication reconciliation.**


Medication Reconciliation Worksheet
for Post-Hospital Care

How many times are admission orders reviewed?
Is the contacted pharmacy made aware when orders are for a new admission?

How are diagnoses, indications and allergies identified?
Are medications reviewed with the previous facility during report?
Review the Interact Medication Reconciliation Worksheet. How does this compare to the facility's medication reconciliation processes?

Tuesday

After admission, every nurse that gives medication is responsible for giving medication correctly. Along with the Five Rights of medication administration (**right patient, right drug, right dose, right route, right time**), nurses will need to be aware of the indications for medications, any needed lab work or monitoring and possible adverse reactions.

Discuss the systems in place at your facility to ensure medications are given properly. Review the Five Rights with staff.

Wednesday

Doctors, nurse practitioners and pharmacists should be involved in medication reconciliation.

Ask your team these questions:

1. When is this review triggered in your facility?
2. If there has been a behavior change, is medication reviewed for possible side effects?
3. Who can you reach out to internally and at the contracted pharmacy if you are unsure if orders or administration are appropriate or with any other questions?

Remember you have medication experts on your team.

Thursday

Medication reconciliation should not stop at admission. Changes in condition or changes in locations should trigger a medication review.

Are physicians or pharmacists notified when a resident's condition changes? Are they notified when a resident becomes more or less compliant with medication or diet?

These changes could result in the need for closer monitoring or medication changes.

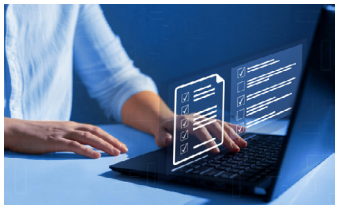
Residents with over eight scheduled medications are at higher risk for drug-to-drug interactions.

Do you have a process to handle those higher risks?

Friday

Medication needs to be administered according to company policy. Using a computer system to assist with medication administration helps prevent medication errors. **Discuss the drawbacks staff see in using the computer system.**

Do you experience fatigue due to repeated drug interaction alerts? How can those drawbacks be eliminated? **Review some** lessons learned about implementing and using technology in a clinical setting.



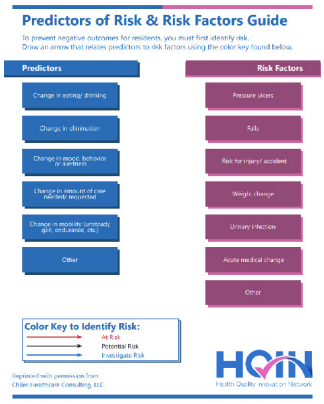
Week 7: Discharge Analysis

Monday

Tuesday

A resident may discharge unexpectantly for a number of different reasons. It might seem like there was nothing that would have prevented an ED visit or hospitalization but often processes could have identified a problem before it resulted in discharge. Facilities must have processes in place for early identification of changes in condition and to communicate those changes to ensure timely interventions.

Assess your facilities communication processes. Do you have a huddle meeting with frontline staff to share and discuss important information? If not, consider using the HQIN Huddle Toolkit to implement huddles at start of shift and end of shift, quality improvement huddles, new resident huddles or "Everyone Stands Up Together" huddles where the daily standup meeting is conducted on the unit(s) with frontline staff.

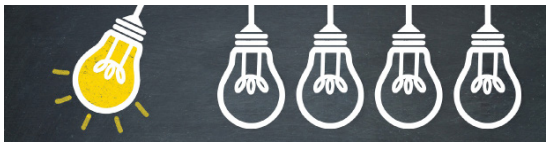


Also, INTERACT® (Interventions to Reduce Acute Care Transfers) offers communication tools at no cost including Stop and Watch Early Warning Tool, SBAR (Situation, Background, Appearance and Review and Notify) and the Medication Reconciliation Worksheet.

Wednesday

Other adverse events should trigger the same evaluation as unplanned discharges. Reviewing adverse events helps to find opportunities for improvement that can prevent future ED visits or hospitalizations.

- When issues are identified or communicated, how are these issues reviewed?
- Are they reviewed at risk management meetings?

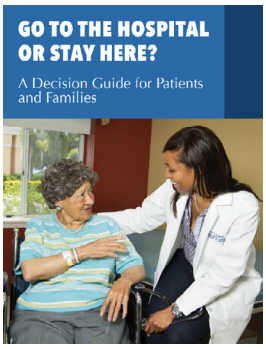


Discuss how possible opportunities are communicated to the risk management team. Use the EMR to help identify factors like changes in condition, falls, medication errors, etc. to include in risk management meetings.

Thursday

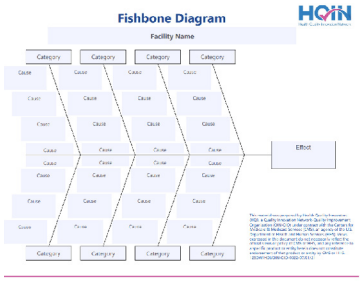
Residents and families play an important role in preventing ED visits and hospitalizations. Care planning and advanced care planning should be discussed with patients and families regularly. **Review CMS'** Go to the Hospital or Stay Here Decision Guide **for patients and families. Make use of the resource to assist patients and families to plan for future care.**

INTERACT® (Interventions to Reduce Acute Care Transfers) also offers care planning tools at no cost including the Advance Care Planning Communication Guide and Identifying Residents who may be Appropriate for Hospice or Palliative/ Comfort Care Order.



Choose your favorite resources as a team and make sure they are available to assist with care planning.

Friday



Sometimes the root cause of an adverse event is not immediately clear. Root cause analysis can help uncover the cause, and a fishbone diagram can assist with finding it. Fill out the problem (adverse event) at the head of the fish. As you brainstorm possible causes, group them into categories. Use these categories to identify areas where improvement would be beneficial.

When you have identified a problem and root cause, you will want to implement quality improvement interventions. Making changes to systems and procedures is sometimes necessary, but interventions that are not sustainable are unlikely to be effective. **Consider the problems and root causes you have noted this week.** Use the QAPI Sustainability Decision Guide to assist with choosing effective interventions.

INTERACT® Version 4.5 Tools For SNFs/ Nursing Homes also offers quality improvement resources including an Acute Care Transfer Log, Calculating Hospitalization Rates, Hospitalization Rate Tracking Tool, Quality Improvement Tool for Review of Acute Care Transfers and Quality Improvement Summary Worksheet.

Week 8: Falls

Monday

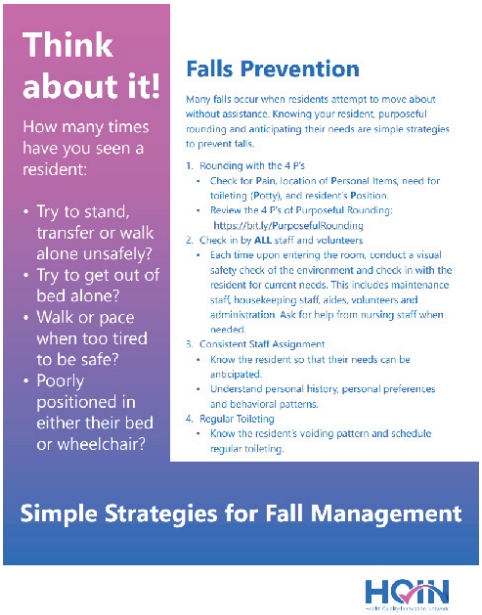
Today is a great day for a discussion on Falls! Talk about environmental hazards that may contribute to a resident falling.

How many can your staff name (wet floors, poor lighting, incorrect bed height, improperly fitting wheelchair, poor shoes, or resident needs such as the need to use bathroom, items not in reach, call bell not in reach)?

If you notice any of these hazards, correct or report immediately! Involve physical therapy, occupational therapy and your pharmacy consultant in the fall prevention program.

Print the Environmental Safety resource and review with your team, then post it for other staff members to have for reference. Create a Falls bulletin board to display educational resources to reduce falls for your team.

Tuesday



How many times have you seen a resident try to stand, transfer or walk unassisted? It takes a team, working together, to reduce falls.

If you see a resident that looks unsafe, let someone know. Purposeful rounding can be conducted by anyone (housekeeping, dietary, maintenance, nursing, social services, activities and volunteers) who is "walking" in the facility. It does not have to be a nurse. Everyone in the department should be aware of residents and help keep them safe!

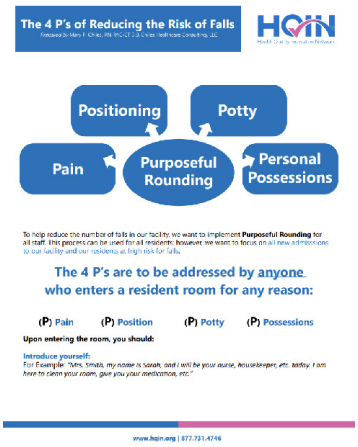
Print the Falls Prevention resource and share with team members, then post it for others to reference.

Wednesday

You talked about purposeful rounding yesterday. **Today, print and post the following resource on** The 4 P's of Reducing the Risk of Falls **and discuss them in depth with your staff.**

Also, download these 4 P's Cards **that can be cut out and shared with staff.**

What are the 4 P's to reduce fall risk? Pain. Potty. Positioning. Possessions. Implementing purposeful rounding for all staff can significantly reduce fall risk.



Thursday

It is time to talk about engagement and sleep hygiene. Improving mobility, psychosocial well-being and sleep hygiene has been shown to reduce fall risk.

Print and post Simple Strategies to Prevent Falls: Engagement and Sleep Hygiene **for your team.**

Discuss ways your team can improve sleep for your residents.

Friday

1. Who is tracking falls in your facility and are they including it as part of QAPI? Let the team know.
2. Is there a system of sharing information on falls and letting all members of the team know the facility's fall data?
3. Was your team able to create a falls bulletin board?

Designate a "falls champion" today and continue to find great information on fall reduction to share with your team. Charts and graphs can be great to share! Download the Health Quality Innovation Network (HQIN) Nursing Home Falls Tracking Tool and implement it into your team processes.

POST FALL EVALUATION COMPONENTS FROM AMDA CLINICAL PRACTICE GUIDELINES

Risk Category	Fall Risk	Post-Fall Evaluation
Fall History	Review history of falls	Review history of recent or recurrent falls and the circumstances of those falls
Medications	Review record for medications that could pose exposure to falls. Barbiturates Benzodiazepines Antidepressants (tricyclics, selective serotonin reuptake inhibitors, serotonin-norepinephrine reuptake inhibitors) Antiadrenergic agents Antihistamines Antiparkinsonian agents Antipsychotic medications (typical and atypical) Barbiturates (short and long acting) Diuretics Opioid analgesics Sedative hypnotics	· Review record for medications or combinations of medications that could pose exposure to falls · Stop or reduce the dosage of as many of these medications as possible · Review record for recent changes in the medication regimen that may have increased fall risk

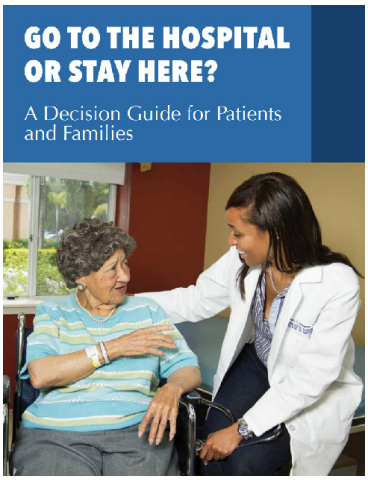
Week 9: Purposeful Conversations

Monday

Having purposeful conversations with residents and family members is a best practice and can strengthen admission and care planning processes, increase resident and family participation in care, and reduce avoidable transfers back to the hospital.

Purposeful conversation refers to intentional and meaningful communication that serves specific objectives or goals. It goes beyond casual chitchat and aims to achieve specific outcomes.

Print and discuss with the team the following resource, Go to the Hospital or Stay Here. Social services staff or nurses can use this decision guide to facilitate clear and informative conversations of a resident's choice to "Go to the Hospital or Stay Here."

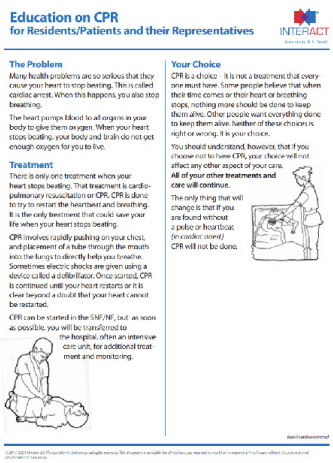


Tuesday

End of Life Purposeful Conversations – What are the Residents Wishes?

Do all of your residents have a documented advanced directive? **Review which residents are a full code, and which are a Do Not Resuscitate (DNR). Discuss how staff know which residents are DNR and what the current process is to communicate this to all staff.**

Print and discuss Education on CPR for Residents/ Patients and their Representatives **with the clinical team to guide conversations when providing education for residents and their family.**


Education on CPR
for Residents/Patients and their Representatives

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardio-pulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves rapidly pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

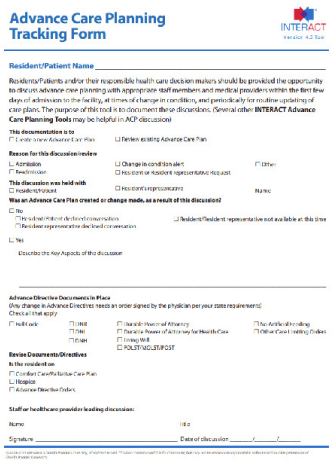
CPR can be started in the SNF/NF, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.

Your Choice

CPR is a choice – it is not a treatment that every one must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care. All of your other treatments and care will continue.

The only thing that will change is that if you are found without a pulse or heartbeat (in cardiac arrest) CPR will not be done.


Advance Care Planning
Tracking Form

Resident/Patient Name

Staff or healthcare provider leading discussion:

Name

Title

Signature

Date of discussion

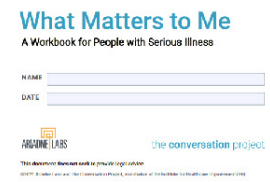
Advanced directives should be reviewed upon admission, quarterly, and if a change in condition would warrant it. Use this Advance Care Planning Tracking Form **to assist with tracking these reviews.**

Wednesday

It is often helpful to involve the physician or healthcare provider, in addition to the resident and their family in purposeful conversations during care plan meetings.

You may want to have an ad hoc care plan meeting if a decline in condition is noted. **Discuss with the team the importance of being proactive with change in condition.** Consider inviting the physician or nurse practitioner to participate in a care plan meeting to participate in difficult conversations.

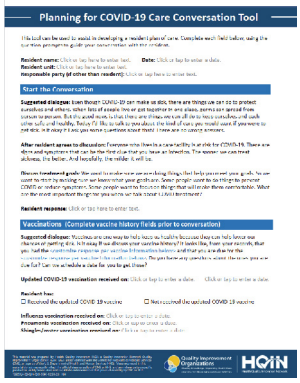
Print and discuss A Patient's Guide to Serious Illness Conversations **from the Institute for Healthcare Improvement to guide these conversations.**



Thursday

Advanced care planning for vaccinations is a best practice. The Planning for COVID-19 Care Conversation Tool can assist with having purposeful conversations centered around vaccinations upon admission and at quarterly care plan meetings.

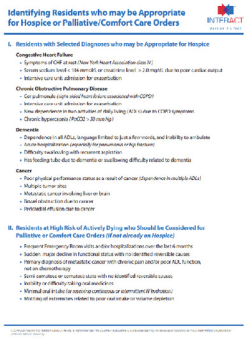
Print and share the same resource with the admissions and clinical care plan team and discuss how it can be incorporated into current practice.



Friday

Disease process education for residents and families is important. It may be appropriate to conduct purposeful conversations regarding palliative care and/or hospice care during these conversations.

Print and share Identifying Residents Who May be Appropriate for Hospice or Palliative/Comfort Care Orders **to identify residents who may be appropriate for this type of care.**



Also, print and share Myths about Palliative and Hospice Care Infographic **with your social service and clinical team to guide conversations regarding certain myths about palliative care and hospice.**