Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mountain-Pacific Quality Health

April 2015
through
October 2016

NATIONAL NURSING HOME QUALITY CARE COLLABORATIVE

MONTHLY PLANNER

Welcome to the National Nursing Home Quality Care Collaborative

The Mountain-Pacific Quality Health National Nursing Home Quality Care Collaborative (NNHQCC) Support Team created this monthly planner to help guide your participation in the Collaborative.

The goal of the Collaborative is to support you in creating a self-sustaining approach to improving safety and quality of care, resulting in the prevention of adverse events and reduce risks to residents and caregivers.

Throughout the project, Mountain-Pacific will work with you on a variety of topics to help you apply appropriate methodologies, like Quality Assurance Performance Improvement (QAPI) to your day-to-day efforts to provide quality care and services to your residents.

Meet Mountain-Pacific's NNHQCC State Leads

Pat Fritz, BSN, RN, BC, NHA
Wyoming
(307) 568-2797
Pat.Fritz@area-h.hcqis.org

Pamela Longmire, RT, BAS
Montana
(406) 457-5885
Pamela.Longmire@area-h.hcqis.org

Joy Yadao, RN
Hawaii
(808) 545-2550 ext. 6022
Joy.Yadao@area-h.hcqis.org

Leiza Johnson, RN, BSN
Alaska
(907) 561-3202 ext. 6
Elizabeth.Johnson@area-h.hcqis.org

The NNHQCC Pledge

As a part of the NNHQCC, you and your facility agree to:

- ✓ Remain active in the Collaborative through July of 2019
- ✓ Engage a facility team that includes senior leaders, frontline staff, residents and families to support quality improvement activities
- ✓ Participate in Learning and Action Network (LAN) events, including those hosted by Mountain-Pacific or other partners
- ✓ Participate in onsite, regional workshops and/or virtual events to gain and share knowledge and skills in quality improvement efforts
- ✓ Support the development of strategies for improving overall quality within your facility by
  - Forming an interdisciplinary team to work with Mountain-Pacific to improve systems of care in areas identified as needing improvement
  - Utilizing a data-driven and proactive approach to identify opportunities for improvement
  - Addressing gaps in systems and/or deficiencies in care by developing resident-focused strategies/interventions
  - Submitting requested data or reports to support NNHQCC efforts and data sharing
  - Participating in educational sessions, conference calls or webinars
  - Sharing best practices and lessons learned
- ✓ Publicly disclose participation in the NNHQCC
- ✓ Submit periodic progress reports on facility activities to Mountain-Pacific

Three Keys to Quality Improvement

Set Goals

Setting goals helps you stay focused.

Track Progress

Tracking keeps you from focusing on failures and helps get the best results.

Test, Test, Test!

Testing changes on a small scale helps evaluate cost, impact and side effects.

- **Get everyone involved in setting goals.**
- **Set stretch goals. Choose national, state and local performance benchmarks and beat them! Set specific numerical performance improvement goals that staff and leadership will own, believe in and understand their role in achieving.**
- **Measure important indicators of care that are relevant and meaningful to your residents.**
- **Openly and transparently share your performance data with staff, board, residents and families.**
- **Prioritize opportunities for improvement.**
- **Use PDSAs to test small, incremental changes.**
- **Use an action plan template that defines who and when to establish timelines and accountability.**
- **Use a multidepartment and multidisciplinary approach to improvement. Involve residents, external stakeholders and any person who cares about the process being improved.**
- **Celebrate success and find creative ways to reward and recognize staff who contribute to achieving goals.**

How to Set SMART Goals

SPECIFIC Use the 3 Ws – What do you want to accomplish? Who will be involved/affected? Where will it take place?

MEASUREABLE How will you know the goal is reached? What is the measure you will use? What is the current data figure? What do you want to increase/decrease that number to?

ATTAINABLE Defend the rationale for setting the goal measure. Is it based on a best practice, average score or benchmark? Is it a stretch without being too unreasonable?

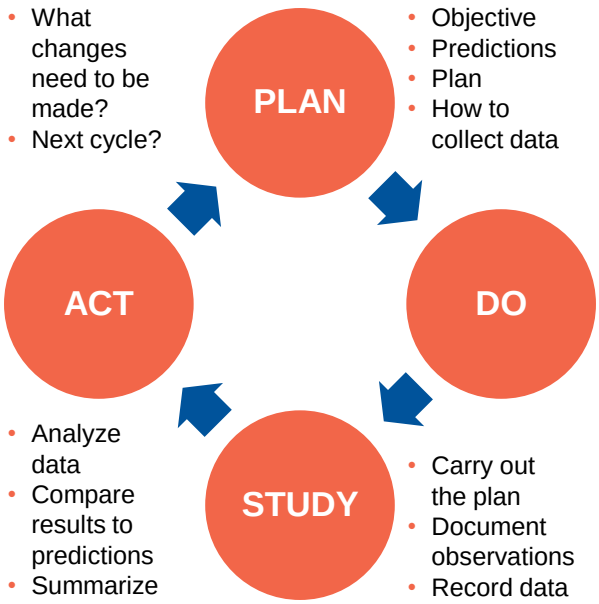
RELEVANT How does the goal address a priority facility issue or problem?

TIME-BOUND What is the target date for achieving the goal?

Getting to the "Root" of the Problem

There is a danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed and/or the problem may be a symptom of a larger issues. What seems like a simple issue may involve a number of departments.

Root cause analysis / root kawz *uh*-nal-*uh*-sis / (noun): A term used to describe a systematic process for identifying contributing causal factors that underlie variations in performance; also known as RCA



Action step	Who's responsible?	Date completed
Using a methodical approach, determine potential root cause(s) underlying the performance issue(s).		
Determine which factors are controllable.		
Ensure the PDSA cycles address the root cause(s).		

Questions for team discussion:

What are the obvious and less obvious reason(s) the problem surfaced?

What is the root of those factors?

What systems and processes (not people) are involved?

APRIL 2015				
MON	TUE	WED	THU	FRI
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22 QAPI in Action: Collaborative Kickoff	23	24
27	28	29	30	

Monthly Quick Tip:

If you don't already, create and publish a monthly birthday list with resident and staff birthdays to emphasize you work together and celebrate together.

My progress notes:

My best PDSA this month:

What I plan to do next month:

What is QAPI?

QAPI is the merger of two complementary approaches to quality management.

Quality Assurance (QA)

- A process of meeting quality standards and assuring that care reaches an acceptable level
- A reactive, retrospective effort to examine why a facility failed to meet certain standards
- Improves quality, but efforts often end once the standard is met

Performance Improvement (PI)

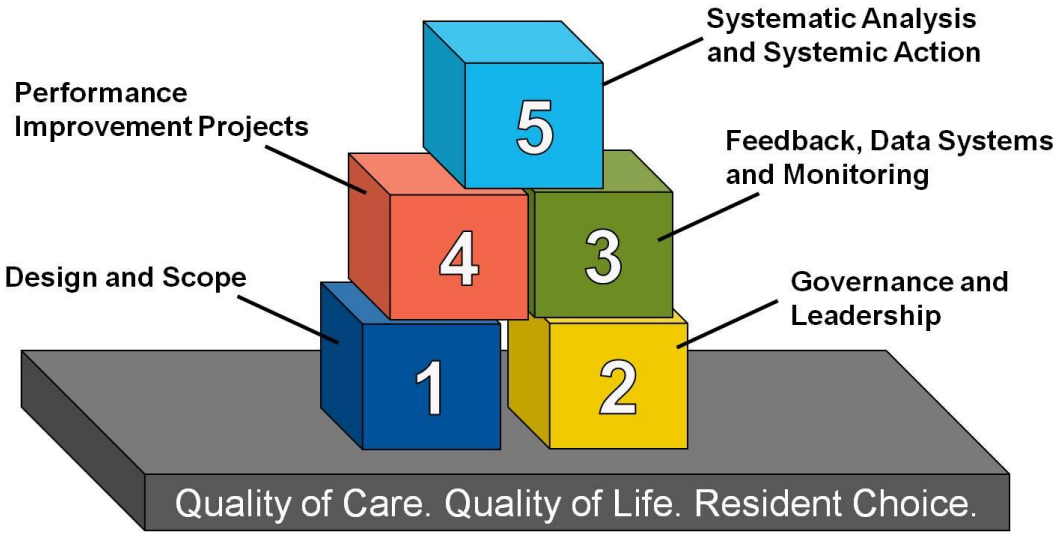
- Also known as Quality Improvement (QI)
- A proactive and continuous study of processes
- Intended to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems

Quality Assurance Performance Improvement (QAPI)

A systematic, comprehensive, data-driven, proactive approach to improving the quality of life, care and services for nursing home residents

Five Elements for Framing QAPI in Nursing Homes

The Centers for Medicare & Medicaid Services (CMS) has identified five strategic elements that are basic building blocks to effective QAPI. These provide a framework for QAPI development.



The five elements are your strategic framework for developing, implementing and sustaining QAPI.

- Your QAPI plan should address all five elements.
- The five elements are all closely related. You are likely to be working on them all at once. They may need attention at the same time, because they will all apply to the improvement initiatives you choose.
- Your plan is based on your own center's programs and services, the needs of your particular residents and your assessment of your current quality challenges and opportunities.

MAY 2015				
MON	TUE	WED	THU	FRI
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

Monthly Quick Tip:

Do you have an effective quality improvement team? Characteristics of an effective team include:

- **A clear purpose understood by all**
- **Defined roles for each member**
- **Commitment from each member to actively participate**

My progress notes:

My best PDSA this month:

What I plan to do next month:

Staffing: Consistent Assignment and Stability

Why is consistent assignment important?

When residents receive consistent care from familiar providers, they become part of a closer, more caring relationship. Residents and family members feel more comfortable about the care that is being delivered. Consistent caregivers become well acquainted with the residents they care for and readily notice changes and actively address physical/behavioral concerns.

How can I improve staffing stability?

Person-centered care is the cornerstone to ensuring residents receive the best care. Well trained and empowered employees have higher job satisfaction, which leads to staffing stability. Invest in your employees through:

- Listening to their ideas
- Empowering them with training
- Being flexible (consider 4-2 scheduling)
- Monthly staff meetings where staff are safe to address concerns and can actively participate in change

Staffing Best Practices

- **Define position description and the characteristics you want in applicants.**
- **Highlight your mission, values, and culture in the hiring process.**
- **When possible, involve staff, residents and families in the interview process.**
- **Use interview techniques (e.g., open-ended questions) to ensure the best selection is made for a position.**
- **Take candidates to their possible work environment and see how they interact.**
- **Use high quality employee orientation processes and provide regular reviews.**
- **Invest in your employees.**
- **Assign a buddy system to help new or struggling employees.**
- **Encourage questions and teamwork.**

Sharing Topic

Three things we do at our organization to actively support employees:

1. _____

2. _____

3. _____

Questions for other nursing homes and collaborative partners about staffing:

_____

_____

I need help with:

_____

_____

Exciting things to share:

_____

_____

_____

JUNE 2015

MON	TUE	WED	THU	FRI
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30			

Monthly Quick Tip:

Treat residents as they want to be treated. Remember: Your facility is their home.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Root Cause Analysis and Failure Mode Effect Analysis

Be a continuous learning organization.

- **Identify implications and consequences of changes to show inter-connectedness and relationships, intended and unintended**
- **Encourage staff to identify areas for improvement**
- **Involve residents in identifying areas for improvement and to actively participate in developing solutions.**

Why Are RCAs and FMEAs Important?

In 2014, the Office of the Inspector General (OIG) released a report on adverse events in nursing homes. The OIG found that 22% of Medicare beneficiaries experienced adverse events during their nursing home stays. Of those events, 79% resulted in prolonged stay or transfer, and the remaining 20% resulted in either life-sustaining interventions or resident death. Physician reviewers determined that 59% of adverse events were clearly or likely preventable.

Root cause analysis (RCA) and failure mode effect analysis (FMEA) are quality improvement tools to help analyze processes. RCAs and FMEAs may be used to help achieve consistent, safe practices in nursing homes.

Root-Cause Analysis (RCA) – A structured investigation that aims to identify the true cause of a problem; used to develop actions necessary to prevent a problem from happening again

Failure-Mode Effect Analysis (FMEA) – A proactive way to identify risk-prone points in a process and come up with ways to prevent or minimize error

Resources:
Institute for Healthcare Improvement: www.ihi.org
Centers for Medicare & Medicaid Services: www.cms.gov (Search RCA and/or FMEA for resources.)
Agency for Healthcare Research & Quality Patient Safety Network: www.psnet.ahrq.gov

Sharing Topic

Three processes we might consider for RCA or FMEA:

1.

2.

3.

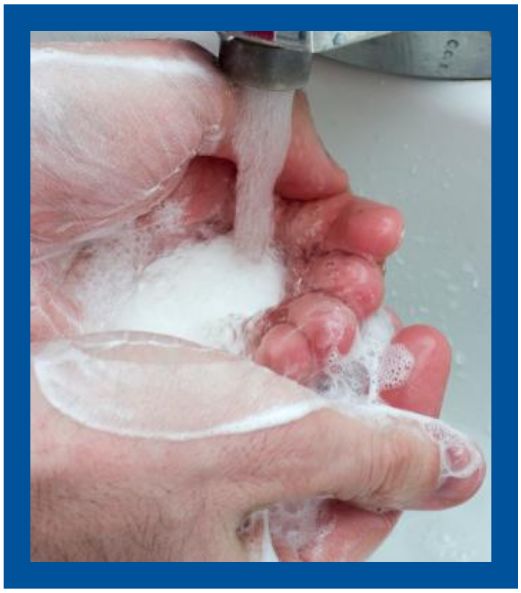
Questions for other nursing homes and collaborative partners regarding RCA or FMEA:

I need help with:

Exciting things to share:

JULY 2015

MON	TUE	WED	THU	FRI
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	31



Monthly Quick Tip:

Clean hands are caring hands. Be sure to use soap and water or antibacterial gel before and after touching a resident. And if a resident asks you to wash your hands, say thank you! We all need reminders sometimes.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Mountain-Pacific's Peer Coaching Program

A key to integrating successful behaviors into daily practice is through Peer Coaching. Peer Coaches help ensure proven concepts are understood and tools and strategies implemented are used accurately and appropriately.

Peer Coaches: Leaders of Change

Our goal is to have available a host of nursing home staff, leaders and residents/family members who have expertise in their respective areas of nursing home operations or perspectives and are willing to share and support their peers.

What is the program's purpose?

Mountain-Pacific's Peer Coaching Program aims to serve as an integral part of the nursing home community, promoting and supporting quality improvement efforts in long term care facilities. Peer Coaching is a key component of the National Nursing Home Quality Care Collaborative.

Why is the program important?

There is no better or faster method of supporting performance improvement than learning from and with your peers. The Peer Coaching Program is a foundation for a strong network of colleagues working together to support and learn from one another.

Resources:

- **Mountain-Pacific Quality Health: www.mpqhf.org (Go to Quality Improvement Tools & Resources.) If you want to be a Peer Coach or need assistance from one of our Peer Coaches, please contact your Mountain-Pacific state representative.**
- **Agency for Healthcare Research and Quality (AHRQ): www.ahrq.gov (Go to For Professionals and click on Curriculum Tools under Education & Training. Then click on TeamSTEPPS.)**

www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/fundamentals/module9/slcoaching.html

Sharing Topic

Three things we do to promote peer learning at our organization:

1.

2.

3.

Questions for other nursing homes and collaborative partners regarding the Peer Coaching program:

I need help with:

Exciting things to share:

AUGUST 2015				
MON	TUE	WED	THU	FRI
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24	25	26	27	28
31				

"If you want to bring a fundamental change in people's belief and behavior… you need to create a community around them where those new beliefs can be practiced, expressed and nurtured."

— **Malcolm Gladwell, author of *The Tipping Point: How Little Things Can Make a Big Difference***

My progress notes:

My best PDSA this month:

What I plan to do next month:

Antipsychotic Medication Use

Residents who receive an antipsychotic medication are almost 50% more likely to fall. Those older than 70 are 3.5 times more likely to be admitted to a hospital due to an adverse reaction from an antipsychotic medication. The U.S. Food and Drug Administration (FDA) has a black box warning for antipsychotic medication use among people with dementia, and there are no FDA-approved antipsychotic medications to use when people with dementia are agitated.

How does this relate to your residents? Antipsychotics can affect their quality of life in many ways. Frail seniors are more likely to experience adverse effects from these medications, which can contribute to medical and psychosocial decline. There is a national focus on reducing the use of antipsychotics in nursing homes. The Medicare Compare website has recently added antipsychotic rates to the star-rating metrics and report. The public is watching!

Best Practices:

Strive to prevent problems and treat when necessary. When residents act out, it is often because of an unmet need. While pain is the most common, simple things like constricting clothing or hunger can create tension and unrest.

Connect with residents in a celebration of their life. By getting to know your residents' life stories, you gain insight to their personalities and preferences that can be useful in addressing behavior problems.

Resources:

- Partnership to Improve Dementia Care: www.cms.gov
- Dementia Care in Nursing Homes: www.dementiacareinnursinghomes.com
- American Society of Consultant Pharmacists: www.ascp.com
- Advancing Excellence in America's Nursing Homes: www.nhqualitycampaign.org

Sharing Topic

Three things we do at our organization to limit antipsychotic use:

1.

2.

3.

Questions for other nursing homes and partners about antipsychotic use:

I need help with:

Exciting things to share:

SEPTEMBER 2015

MON	TUE	WED	THU	FRI
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30		

Monthly Quick Tip:

Reduce and/or eliminate use of antipsychotic medications for residents with dementia by

- **viewing behaviors as attempts to communicate needs;**
- **providing information to all direct staff on individualized and proven approaches that successfully address residents' needs;**
- **meeting residents needs rather than accepting behaviors as "attention seeking";**
- **promoting a consistent staff environment with normal routines.**

My progress notes:

My best PDSA this month:

What I plan to do next month:

Mobility: Increasing Residents' Well-Being

Research has shown that being able to move easily helps residents' physical function and psychological well-being. Increasing residents' activities of daily living (ADLs) is important for:

- Stronger bones and muscles – making fractures less likely
- Improved heart and lung function
- Improved sleep
- Improved appetite, which may help to maintain weight.
- Improved mental alertness, mood and self-confidence
- Improved balance and ambulation
- Greater independence and social interaction and engagement in the world around them

How can we improve residents' ADLs?

- Make resident mobility a facility-wide priority, i.e., it is everyone's responsibility, not just therapy staff
- Ensure mobility is addressed in every resident's care plan
- Develop stretching, exercise and/or walking programs

Resource:
Advancing Excellence, Illinois Council on LTC – Search for YouTube video "Nursing Home Residents Prepare to Play"

Best Practices for Increasing Residents' Well-Being

- **Create a recreational wish list (games, art, gardening, volunteering) that meets the individuality of residents**
- **Focus on keeping residents active in their families' lives and the community**
- **Utilize open-ended questions to learn about what residents enjoy doing in their spare time**
- **Involve residents in creating decorations and decorating their residences**
- **Speak with residents' families and learn what residents enjoy**
- **Invite family members to enjoy activities with the residents**
- **Go on outings: Shopping, see the changing fall colors, attend a religious service, community event, play**

Sharing Topic

Three things we do to support increased ADLs in our organization:

1.

2.

3.

New ideas for increasing ADLs:

I need help with:

Exciting things to share:

OCTOBER 2015				
MON	TUE	WED	THU	FRI
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

Monthly Quick Tip:

Try to view concerns, issues or problems at your facility through your residents' eyes. Ask: How would this make me feel if this issue was effecting me/my home?

My progress notes:

My best PDSA this month:

What I plan to do next month:

The 3 Ds – Depression vs. Delirium vs. Dementia

"The 3 Ds" are the three most common mental health conditions among older adults.

1. **Delirium**
   Disturbance of awareness, frequently attributable to underlying infection, medication toxicity or illness
2. **Depression**
   Disturbance of mood; feelings of worthlessness, guilt, sleeplessness and weight loss are indicators of depression and a history of depression in young adulthood is a risk factor for late life depression
3. **Dementia**
   Disturbance of memory; the most common chronic psychiatric illness in America's nursing homes

Why is this important?

Approximately 20% of people over the age of 65 suffer from **depression**, and, in nursing homes, the prevalence may can be as high as 50%. **Delirium** is often overlooked in the context of **dementia**, but prevalence of delirium superimposed on dementia ranges from 22% to 89% in individuals over 65.

Two commonly cited deficiencies in nursing homes are F-309 Provide Care/Services for Highest Well Being and F-279 Develop Comprehensive Care Plans. Both address the need to correctly recognize the differences between the 3 Ds and to plan for residents' individual needs.

Resources:

- Cornell Depression Scale for Depression in Dementia: **www.amda.com**
- Dementia Care in Nursing Homes: **www.dementiacareinnursinghomes.com**
- Geriatric Depression Scale: **www.stanford.edu/-yesavage/GDS.html**
- Advancing Excellence in America's Nursing Homes: **www.nhqualitycampaign.org** Click on Goals and look for tools under Person-Centered Care

Sharing Topic

Three things to help staff recognize differences between the 3 Ds:

1.

2.

3.

Questions for other nursing homes and partners about the 3 Ds:

I need help with:

Exciting things to share:

NOVEMBER 2015				
MON	TUE	WED	THU	FRI
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	*Happy Thanksgiving!*			

Monthly Quick Tip:

Complaints from residents or their families are opportunities to provide better care and increase resident satisfaction. Their complaints can often help you identify more general problems, so you can see the big picture of the long-term care you provide.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Best Practice Advice from the Alzheimer's Association

- **Include the person with dementia in conversations with family, friends and providers**
- **Do not make assumptions about the person's ability to communicate**
- **Speak directly to the person and listen to him/her about how he/she is doing**
- **Give the person time to respond. Do not interrupt or finish sentences, unless the person asks for help or becomes increasingly frustrated**
- **Explore which method of communication is the most comfortable for the person, i.e., written notes can be helpful when spoken words seem confusing**
- **Speak slowly and clearly**
- **Always treat the person with respect and never talk down to them**

Sometimes emotions being expressed are more important than what is being said. Look for the feelings behind the words.

Communicating with Residents with Dementia

Effective communication:

- Reduces anxiety and confusion
- Improves your relationship with the resident
- Informs you of discomfort, pain, dental/vision problems
- Builds trust
- Improves cooperation
- Improves your satisfaction and success as a caregiver
- Empowers the resident and reduces feelings of depression

Good communication includes:

- Maintaining eye contact on the same level
- Avoiding criticism or correcting
- Listening for meaning from what is being said and repeating back for clarification
- Giving visual cues
- Asking one question at a time, as multiple questions can be overwhelming

Resource:
Alzheimer's Association: www.alz.org

Sharing Topic

Three things to improve communication with residents with dementia:

1. _____

2. _____

3. _____

Questions for other nursing homes and partners about dementia:

_____

_____

I need help with:

_____

_____

Exciting things to share:

_____

_____

DECEMBER 2015				
MON	TUE	WED	THU	FRI
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

Monthly Quick Tip:

For some of your residents, the best way to prevent falls is exercise. Make low-impact, strength-building exercises part of the activities you offer at your facility and see stronger residents and less falls.

Happy Holidays!

My progress notes:

My best PDSA this month:

What I plan to do next month:

Hand Hygiene and Infection Control

Infections are a leading cause of death and diminished quality of life for nursing home residents.

From a CMS survey perspective, infection control citations (F441) have doubled since 2008, now cited as deficient practice in over 40% of all LTC surveys nationally (according to 2013 data). Poor hand hygiene practices are the most frequently cited infection control problem in nursing homes, appearing in 70% of all F441 citations (2013-2014 data).

Best Practices for Infection Control:

- **Strive to prevent problems and treat when necessary.** Identify opportunities to actively prevent infections, apply transmission-based precautions and ensure all staff understand the importance of their roles in preventing infections among residents.

  Recognize hand hygiene as the most important contribution to infection prevention in any health care setting or living environment.

- **Track your progress.** Plan and conduct relevant surveillance activities of both outcomes and prevention processes. Use surveillance data to measure and inform QAPI systems on the impact of prevention practices for your residents.

Resources:

- **Quality of Care in Skilled Nursing Care Centers, AHCA, 2013: www.ahcancal.org**
- **Nursing Homes and Assisted Living, CDC resources: www.cdc.gov/longtermcare**

Sharing Topic

Three things we do at our organization to prevent infection:

1.

2.

3.

Questions for other nursing homes and partners about infection prevention:

I need help with:

Exciting things to share:

JANUARY 2016

MON	TUE	WED	THU	FRI
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

"Culture does not change because we desire to change it. Culture changes when the organization is transformed; the culture reflects the realities of people working together every day."

— Frances Hesselbein, author of *The Key to Cultural Transformation, Leader to Leader*

My progress notes:

My best PDSA this month:

What I plan to do next month:

Music Therapy: Keeping Residents Safe with Sound

What is the challenge?

Many nursing home residents have some form of dementia and/or communicate via unpleasant behavior. To modify behavior, antipsychotic medication is often used but might not be clinically supported and can be harmful to a resident's health.

Why use music therapy?

Music has been shown to be calming, reduce agitation, pain, anxiety, stress, increase activity, improve communication, and enrich the lives of people in a multitude of ways.

Where has music therapy demonstrated success?

Among the 50 states, Wisconsin has moved from *tenth to fourth place* in reducing the use of antipsychotic medications in nursing homes. The Music & Memory program is one of the alternatives Wisconsin implemented to reduce antipsychotic medication use.

A facility in Norwood, New Jersey, hired a music teacher who had staff make a "music journal" and play different types of music throughout the facility. After discovering and playing residents' favorite music, staff saw a reduction in unwanted behavior, and antipsychotic medication use declined from 11 to 2%.

How does music affect the resident?

Music therapy can improve residents' quality of life, health and interactions with staff, while decreasing stress, anxiety and confusion.

Improving Quality of Resident Life

Create a "resident life committee" of both staff and residents who come together to learn and share residents' preferences for activities. Use the committee's suggestions to improve residents' experiences. For example, add residents' favorite foods to the menu or learn about residents' favorite music artists or genres and plan a musical event at the facility or take them to a concert in the community.

Resources:

- Music & Memory: www.musicandmemory.org
  Click on News & Events and search Wisconsin
- AMDA: www.caringfortheages.com
  Search for article by Christine Kilgore, "Efforts to Reduce Antipsychotic Use in Facilities Is Boosting Alternative Medicine"
- American Health Care Association: www.ahcancal.org
  Click on Quality Improvement, then AHCA/NCAL Quality Initiative, then Safely Reduce the Off-Label Use of Antipsychotics

Sharing Topic

Three things we could do to implement the use of music therapy:

1.

2.

3.

Staff who would champion this effort:

Residents who may benefit from music therapy:

FEBRUARY 2016				
MON	TUE	WED	THU	FRI
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29				

Monthly Quick Tip:

To focus your priorities each day, ask yourself these questions:

- **How important and urgent is each task?**
- **Does this task represent any short- or long-term goals?**
- **What will happen if the task is placed on a low priority?**
- **Who and what is it for?**
- **Which tasks and goals will benefit the department or facility most?**

My progress notes:

My best PDSA this month:

What I plan to do next month:

Unplanned Weight Loss in Residents

Strive to prevent problems and treat when necessary.

- Recognize resident conditions and therapeutics that might contribute to unplanned weight loss.
- Monitor weight changes and look at the behaviors, medications, or resident life events associated with unplanned weight change.
- Encourage and assist residents and family to actively promote a positive dining experience and honor resident preferences for food choices.
- Identify factors that hinder proper nourishment and implement person-centered care practices to reduce these barriers.

Transition with care.

- Engage all staff members to look for changes in resident conditions and empower communication among staff to ensure changes are recognized promptly.
- Be consistent and positive at mealtime.

Why is this important?

Residents with unintentional weight loss are at higher risk for infection, falls and other conditions that significantly impact resident health. It is also clear that involuntary weight loss contributes to increased disease complications, physical disability and reduced capacity to heal.

Unplanned weight loss can be attributable to depression, dysphagia and some psychotropic drugs. Weight loss is often the observed outcome of an unanticipated consequence of treatment.

Resources:

- The Commonwealth Fund
  www.commonwealthfund.org
  Search key words: Malnutrition, weight loss, dehydration
- Pioneer Network
  www.pioneernetwork.net
  Search key words: Dining, culture change

Sharing Topic

Three things we do to promote a positive mealtime experience:

1.

2.

3.

Questions for other nursing homes and partners about weight loss:

I need help with:

Exciting things to share:

MARCH 2016

MON	TUE	WED	THU	FRI
	1	2	3	4
7	8	9	10	11
14	15	16	17	18
21	22	23	24	25
28	29	30	31	

"No matter where someone lives, they should have the opportunity to direct their life to the greatest extent possible."

— "Person-Centered Living"
Pioneer Network

My progress notes:

My best PDSA this month:

What I plan to do next month:

Providing Person-Centered Care

Connect with residents in a celebration of their lives. Distinctive nursing homes create an environment where the resident always comes first. The focus is honoring resident preferences and keeping them active in their families' lives and the community. Provide opportunities for residents to "give to others" and promote meaning into their life.

Provide exceptional, compassionate care that treats the whole person. A focus on the whole person requires staff to know residents well. They can anticipate residents' needs and know their preferences. Consistently assigned, direct care staff foster positive relationships and implementation of a person-centered care planning.

Resources:

- www.pioneernetwork.net
- www.nhqualitycampaign.org
- www.edenalt.org

Person-centered care (PCC) promotes choice, purpose and meaning into daily life. It supports nursing home residents in achieving physical, mental and psychosocial well-being that is individually practicable. PCC keeps the person at the center of care planning and decision-making.

Examples of PCC:

- Residents wake up, go to bed, dine and bathe when they choose, and staff alters their work routines to honor the residents' preferences.
- The same staff take care of the same residents. The relationship that develops motivates staff to provide better care and the resident feels more secure, content and happy. Consistent relationships are an important component of a healthy life and a basis for residents' social networks.
- Resident input is sought out before making any decisions that affect them and their daily lives. The nursing home trains and support staff to enable residents to make decision.

Sharing Topic

Three things we do to promote person-centered care:

1.

2.

3.

Questions for other nursing homes and collaborative partners about person-centered care:

I need help with:

Exciting things to share:

APRIL 2016				
MON	TUE	WED	THU	FRI
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

Monthly Quick Tip:

Does everyone know about your facility's QAPI plan? Communicate often and in multiple ways to let staff, residents and families know that anyone can raise quality concerns and that it is safe to do so.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Supporting Advance Care Planning

Talking ACP with Residents

Strong communication between staff and residents/families builds relationships and trust. Having a conversation about a resident's ACP, however, is an important skill for staff to develop and can take some training. For example, do you know the difference between:

- **A living will, a health care power of attorney and Physician Orders for Life-Sustaining Treatment?**
- **Hospice, palliative care, comfort care and a do not resuscitate (DNR) order?**

Although modern medicine helps us to live longer, it still has its limits. That is why it is important to offer **advance care planning (ACP)** support to your residents and their families. Providing both the tools and opportunity to make decisions about their care choices and goals and documenting a person's wishes for end-of-life care:

- Exemplifies holistic, compassionate care
- Shows respect for a resident's physical, emotional and spiritual needs, as determined by their beliefs and values
- Provides awareness and important information for all health care providers and staff

By supporting a resident's ACP, you help reduce uncertainty and stress for that resident and his or her family, should the resident ever be unable to speak for him or herself. Talk to residents and their families about end-of-life care and appointing a health care power of attorney or agent, if they have not already done so on their own.

For more information about ACP, Hospice and palliative care in nursing homes:

- National Hospice and Palliative Care Organization: www.NHPCO.org
- Caring Connections: www.caringinfo.org
- Center to Advance Palliative Care: www.capc.org
- The Conversation Project: www.theconversationproject.org

Sharing Topic

Three things we do to promote advance care planning (ACP):

1.

2.

3.

Questions for other nursing homes and collaborative partners about ACP:

I need help with:

Exciting things to share:

MAY 2016				
MON	TUE	WED	THU	FRI
2	3	4	5	6
9	10	11	12	13
16	17	18	19	20
23	24	25	26	27
30	31			

Monthly Quick Tip:

A great way to inform staff of progress on quality improvement goals is a quick announcement included with their paychecks. Include praise or thanks and any data you have to support the step toward success.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Fall Prevention in Nursing Homes

Why is fall prevention important?

- **About 1,800 people living in nursing homes die from falls each year.**
- **Ten to 20% of falls in nursing homes cause serious injuries, and as many as 6% result in fractures.**
- **Falls are the number one cause of nursing home litigation.**

Recent studies found the major risk factors for falls among nursing home residents include:

- **Muscle weakness**
- **Prior fall history**
- **Balance deficit**
- **Gait deficit**
- **Environmental noise**
- **Poor sleep hygiene**
- **Assistive devices**
- **Vision deficit**
- **Arthritis**
- **Pain**
- **Activities of daily living (ADL) deficit**
- **Depression**
- **Cognitive deficit**
- **Being age 80 or older**
- **Antipsychotic medication use**

With each additional factor, the risk of falling increases exponentially. A resident with more than four of these risk factors has an 80 to 90% risk of falling.

Online Resources:

- Advancing Excellence in America's Nursing Homes: www.nhqualitycampaign.org
- American Health Care Association: www.ahcancal.org
- Institute for Health Care Quality: www.ihi.org
- Centers for Disease Control: www.cdc.gov

Strive to prevent problems and treat when necessary. Preventing falls starts with a thorough assessment and careful care planning to address risk factors. Involve the resident in planning whenever possible and create an invitation to talk about falls.

Transition with care. Many falls occur within the first few days after a medication change and/or admission to a nursing home. Engage all staff members to be especially alert during these times and empower communication among staff to ensure changes are recognized promptly.

Sharing Topic

Three things we do at our organization to prevent falls:

1.

2.

3.

Questions for other nursing homes and our partners about fall prevention:

I need help with:

Exciting things to share:

JUNE 2016				
MON	TUE	WED	THU	FRI
		1	2	3
6	7	8	9	10
13	14	15	16	17
20	21	22	23	24
27	28	29	30	

“The greatest danger in times of turbulence is not the turbulence—it is to act with yesterday’s logic.”

— Peter Drucker, consultant, educator, author and self-described “social ecologist”

My progress notes:

My best PDSA this month:

What I plan to do next month:

INTERACT 3.0 – Tools for Nursing Homes

What is INTERACT?

Interventions to Reduce Acute Care Transfers, or INTERACT, is a program developed by Dr. Joseph G. Ouslander, a professor and senior associate dean for geriatric programs at the Charles E. Schmidt College of Medicine at Florida Atlantic University. The program was created to reduce the hospitalizations of nursing home residents.

Resident re-hospitalizations are common, especially within 30 days after a hospital discharge. Reducing preventable hospitalizations is fundamental to the Centers of Medicare & Medicaid Services (CMS) goals to improve care, improve population health and reduce health care costs.

Teamwork and communication will reduce unnecessary hospitalizations. INTERACT offers tools to help. There are three basic types of INTERACT tools:

1. Communications tools
2. Care paths or clinical tools
3. Advance care planning tools

Online resources:

- www.interact.com
- www.med-pass.com
- www.medline.com

Are you using any of the following INTERACT 3.0 tools?

- Stop and Watch
- SBAR and Change in Condition Note
- Medication Reconciliation
- NH Capabilities List
- NH-Hospital Transfer Form
- Acute Transfer Checklist
- Care Paths tools
  - Dehydration
  - Fever
  - Mental Status Change
  - UTI
  - CHF
- Resident/Family Education Tools
- Advance Care Planning
- Comfort Care Order Set

Sharing Topic

Three INTERACT tools we routinely use at our organization:

1.

2.

3.

Questions for other nursing homes and partners about INTERACT:

I need help with:

Exciting things to share:

JULY 2016				
MON	TUE	WED	THU	FRI
				1
4	5	6	7	8
11	12	13	14	15
18	19	20	21	22
25	26	27	28	29

Monthly Quick Tip:

Email and paperwork are a normal part of work, but can bury you if they are not well managed. Instead of managing them over and over again, try to "touch" emails and/or paperwork just once using RAFT: Route, Act, File or Trash. Do it right away, do it once and be done with it!

My progress notes:

My best PDSA this month:

What I plan to do next month:

Preventing Catheter-Associated UTIs

Asymptomatic bacteruria risk increases *5% each day* a urinary catheter remains inserted in a resident. Indwelling urinary catheters can increase the risk of urinary tract infections, contribute to mechanical trauma to the urethra and bladder, reduce mobility of your residents, increase the risk of pressure ulcers and falls and can even prolong a resident's long term-care stay.

The Office of Inspector General released a report last year that stated 52% of events related to infections in nursing homes were categorized as preventable, and while these types of events resulted in the fewest hospitalizations, they incurred the highest cost. In addition, the most commonly cited deficiency in nursing homes is F-441 (Infection Control, Prevent Spread, Linens).

How does this relate to the resident? An event like a catheter-associated urinary tract infection (CAUTI) can escalate quickly to become a life-threatening infection, if not diagnosed and treated appropriately.

Foster relationships. Welcome and encourage family members to communicate with staff and residents. Proactively provide opportunities for families to communicate, including contact information and who to contact when a resident's condition changes.

Expect and support effective communication with/between staff. Implement a formal method for communication between shifts, e.g., face-to-face meetings/huddles between incoming and outgoing staff or communication journals in residents' rooms. Include input from residents whenever possible.

Resources:

- Agency for Healthcare Research & Quality: www.AHRQ.gov
- Association for Professionals in Infection Control: www.APIC.org

Sharing Topic

Three things we do at our organization to reduce indwelling catheters:

1.

2.

3.

Questions for other nursing homes and partners about CAUTI prevention:

I need help with:

Exciting things to share:

AUGUST 2016				
MON	TUE	WED	THU	FRI
1	2	3	4	5
8	9	10	11	12
15	16	17	18	19
22	23	24	25	26
29	30	31		

Monthly Quick Tip:

If your swamped with work, it is alright to say no. Be clear and honest, and do not hesitate with your no, unless you genuinely want to think it over. Do not give excuses, but feel free to explain your "no." You can also explain that the answer would be "yes" under different circumstances.

My progress notes:

My best PDSA this month:

What I plan to do next month:

Importance of Immunizations for Staff

Vaccinations are a remarkably effective infection prevention strategy and directly impacts residents' quality of life. Among all health care personnel (HCP), 75.2% were vaccinated against the flu in 2013-2014. Rates approached 90% when senior leadership required or recommended vaccination. Aides (57.7%) and non-clinical personnel (68.6%) had the lowest vaccination rates of all HCP. Nationally, only 63% of long-term care HCP were vaccinated against influenza, yet they serve a very vulnerable population.

Resource:
CDC flu vaccination:
www.cdc.gov/flu/healthcareworkers.htm

Be the leader you would want to follow.

Immunization rates among HCP can be driven by senior leadership. Show strong support of staff immunizations and lead by example. Ensure all staff understands the importance of vaccination as a prevention strategy and how they contribute to a higher quality of resident health when immunized against communicable diseases, like influenza.

Track your progress.

Monitor immunization rates among staff and residents and post the results as a visual cue for performance. Use immunization data to drive QAPI activities targeting vaccination awareness.

Sharing Topic

Three things we do at our organization to promote employee immunizations:

1.

2.

3.

Questions for other nursing homes and collaborative partners about staff and resident vaccination activities:

I need help with:

Exciting things to share:

SEPTEMBER 2016

MON	TUE	WED	THU	FRI
			1	2
5	6	7	8	9
12	13	14	15	16
19	20	21	22	23
26	27	28	29	30

Monthly Quick Tip:

Two important components of your QAPI plan are setting priorities and chartering project (PIP) teams. Make sure everyone has an opportunity to participate in these activities.

My progress notes:

My best PDSA this month:

What I plan to do next month:

A Reminder about Preventing Pressure Ulcers

Pressure ulcers provide foci for infection and create a significant health risk for residents. Skin breakdown is often an indicator of complex health issues and may trigger the need for aggressive intervention. As with other complex problems, preventing pressure ulcers requires a team approach. Engage all staff and all disciplines to focus on reducing pressure ulcers, with a primary goal of prevention.

Best Practices for Pressure Ulcer Prevention:

Strive to prevent problems and treat when necessary.

- Identify residents at risk for skin breakdown and assess skin condition at admission to help drive prevention efforts.
- Inspect skin integrity at least weekly using a comprehensive assessment tool.
- Be deliberate and involve multidisciplinary "pressure ulcer prevention" teams, including the resident if possible.
- Recognize (and utilize) proper nutrition as a critical component of prevention.

Track your progress.

- Monitor pressure ulcers among residents and set challenging goals for reduction and prevention.
- Use monitoring data to drive QAPI activities targeting pressure ulcers and post trends as a visual cue for performance.

Test, test, test!

- Continuous evaluation of staff practices keeps practices to standard and emphasizes the importance of proper care in reducing pressure ulcers.

Resources:

- **Advancing Excellence: www.nhqualitycampaign.org/goalDetail.aspx?g=PU#tab4**
- **CDC: www.cdc.gov/longtermcare/index.html**
- **National Pressure Ulcer Advisory Panel (NPUAP): www.npuap.org**

Sharing Topic

Three things we do at our organization to promote healthy skin:

1. _____

2. _____

3. _____

Questions for other nursing homes and partners about pressure ulcers:

_____

_____

I need help with:

_____

_____

Exciting things to share:

_____

_____

OCTOBER 2016				
MON	TUE	WED	THU	FRI
				1
3	4	5	6	7
10	11	12	13	14
17	18	19	20	21
24/31	25	26	27	28

Monthly Quick Tip:

Greet residents with a smile and make eye contact to show you value them. Make this greeting the norm, not the exception!

My progress notes:

My best PDSA this month:

What I plan to do next month:

Pain Assessment and Management

Medical conditions that can be painful in older adults:

- Pressure ulcers
- Amputations
- Venous ulcers
- Infections
- Immobility
- Osteoporosis
- Gout
- Diabetes with neuropathy
- Post-CVA syndrome
- Oral health conditions
- Multiple sclerosis
- Arthritis
- Fibromyalgia
- Post-herpetic neuralgia

Review CMS tag F309 for pain management regulations for nursing homes. Start developing a person-centered protocol and appropriate treatment options for different types of pain. One size does not fit all.

Pain management education and competency is an example of your organization's commitment to **continuous learning**.

Providing **compassionate clinical care** to residents in pain sets your nursing home apart from other settings. Take the time to develop the protocols and skills necessary.

Pain is what the resident says it is. Use words like aching, burning, stabbing, continuous or intermittent in your pain assessment to distinguish between neuropathic, nociceptive and/or somatic pain.

Online Resources:

- The Honor Society of Nursing, Sigma Theta Tau International – Geriatric Pain: www.geriatricpain.org
- Agency for Healthcare Research & Quality: www.AHRQ.org
- The American Academy of Pain Medicine: www.painmed.org

Sharing Topic

Three things we do at our organization to assess residents' pain:

1.

2.

3.

Questions for other nursing homes and collaborative partners about pain assessment and management:

I need help with:

Exciting things to share:

This material was prepared by Mountain-Pacific Quality Health, the Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Montana, Wyoming, Alaska, Hawaii, Guam, American Samoa and the Commonwealth of the Northern Mariana Islands, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-MPQHF-AS-C2-14-15