the Remedi Pulse

A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

MARCH 2015

Survey Solutions

with William Vaughan, BSN, RN
VP of Education & Clinical Affairs

Preventing Hospitalizations in Long-Term Care: Back to the Basics

I began my career as a surveyor in the late 1980s. When it came to hospitalizing a nursing home resident, the motto "when in doubt, send them out" fairly characterized the thinking at the time. Most administrators encouraged the prompt hospitalization of residents to reduce the survey risk while capturing the "free" money provided by Medicaid's bed hold reimbursement policy.

Fast forward to 2015: due to a number of factors, including growing economic pressure, the hospitalization of a nursing home resident is now considered an intervention of last resort.

While some hospitalizations are unavoidable, a study by the Department of Health and Human Services' Office of the Inspector General released in 2014, suggests that a significant number of nursing home residents are hospitalized due to preventable adverse events.

The likely etiologies of these preventable events were identified as follows:

- Appropriate treatment was provided in a substandard way (56%)
- The resident's progress was not adequately monitored (37%)
- Necessary treatment was not provided (25%)
- Error was related to medical judgment, skill, or resident management (14%)
- Resident care plan was inadequate (11%)
- Care plan was incomplete or not sufficient in describing resident's condition (7%)
- The resident's health status was not adequately assessed (4%)

**Note: percentages do not add up to 100 as some events were attributed to more than one etiology.*

Fully complying with several key federal regulations, as outlined below, will likely reduce such errors and resulting hospitalizations.

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FOR MORE INFORMATION
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Please do not hesitate to contact your Remedi consultant pharmacist or account manager if you have any questions or concerns.

Remedi SeniorCare experts will be presenting with webinars and at trade events.

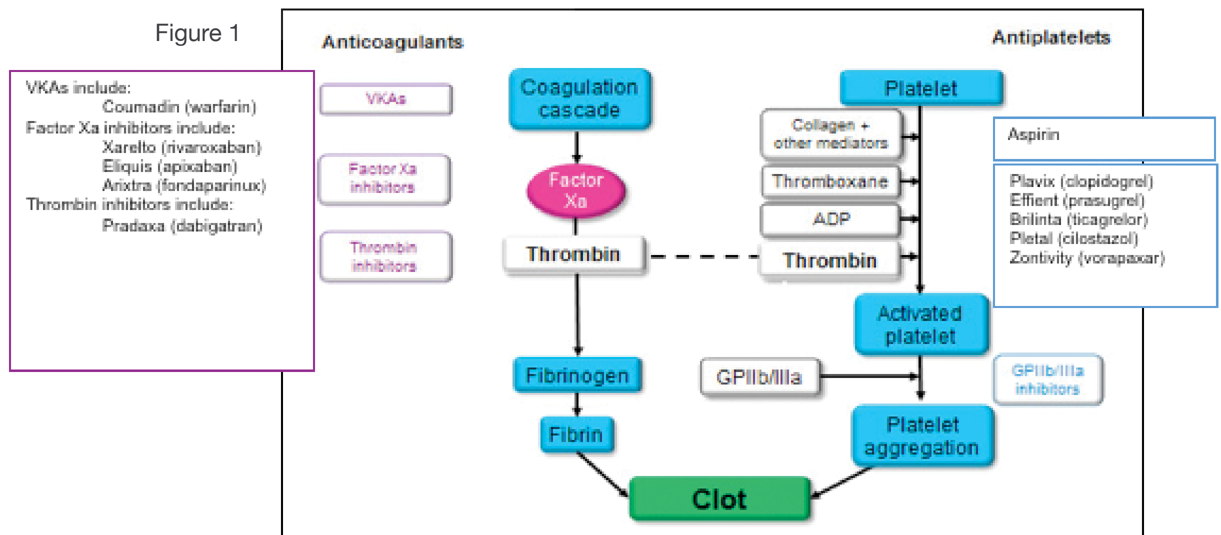
Learn more or attend at RemediRx.com/Events

Keeping Up with Anticoagulants

Prepared by Sarah Brett, Pharm.D., Clinical Consultant Pharmacist

"Did John have his INR checked today? Did we let the dentist know he was on Coumadin? Didn't he just have his dose adjusted? He has a new order for an antibiotic; when does he get his INR checked next?" If this conversation sounds familiar, you've probably cared for someone on warfarin and understand how complicated antithrombotic therapy can be. We know how important it is to appropriately manage our residents who are at an increased risk of bleeding, however, with so many new anticoagulant and antiplatelet agents, it can become difficult to identify these residents. Many of these agents may be new to a patient's regimen upon hospital discharge – used either for clot prevention following hip replacement surgery, new-onset atrial fibrillation, or necessary for the continued treatment of a venous thromboembolism. In order to prevent complications, a delay in therapy and the possibility of additional treatment in the hospital, it is important to identify the medications that require special attention – particularly newly prescribed medications. Determining the indication helps to ascertain if required as ongoing chronic therapy, or if anticipated stop date orders are needed for when treatment or prevention is no longer warranted. The importance of identifying and giving the appropriate attention to residents on anticoagulant therapy is just one reminder of the necessity to become familiar with all new medications. Assisting with understanding new medications we administer is one way in which your pharmacist will continue to work collaboratively with the healthcare team.

Figure 1



Adapted from: www.ThrombosisAdvisor.com

A common source of confusion is making the distinction between anticoagulants and antiplatelet agents. Both of these classes of medications have the same general goal of preventing clot formation and the complications clots may cause, such as heart attack and stroke. Anticoagulants also prevent thrombin generation and keep existing clots from getting larger. Examining Figure 1 shows the differences between the coagulation cascade and platelet aggregation. Remember that both anticoagulants and antiplatelet agents may increase the risk of bleeding and bruising, and taking appropriate precautions is necessary with any resident, who is on a medication from either class. This includes monitoring for stomach pain, black stool, and falls or other accidents.

Newer agents that may start becoming part of common therapy regimens include the anticoagulant Eliquis (apixaban) and the antiplatelet Zontivity (vorapaxar).

Eliquis is available as an oral tablet and the indicators are:

- Treat and prevent of clots in those who have had a deep vein thrombosis (DVT) or pulmonary embolism (PE) or have undergone hip or knee replacement surgery.
- Reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation and may replace warfarin therapy once INR is below 2.0.

Routine INR monitoring is not required for therapy management with Eliquis and there is no rapid reversal agent available. Parameters necessary for appropriate dosing of Eliquis include age, body weight, and serum creatinine. For administration of Eliquis to those unable to swallow whole tablets, current data only supports suspending the crushed tablets in 60 mL of D5W and immediately delivering through a nasogastric tube, which may complicate use in our residents with feeding tubes.

Zontivity was approved for use this past May, 2014 for the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Unlike Eliquis, dosing for Zontivity is not dependent on serum creatinine or renal function. This oral tablet is used in combination with aspirin and/or clopidogrel. There is limited clinical experience with Zontivity as monotherapy or with use in combination with other antiplatelet drugs. Another limitation that will likely impact prescribing of Zontivity for our residents is the contraindication for use in those with a history of stroke, TIA, or ICH.

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Hypodermoclysis: The Hydration Solution

Prepared by: Rebecca Ogden, BSN, RN, CRNI,
Corporate Account Manager

Mable, a new, elderly post-CVA, confused resident, has developed a urinary tract infection. Despite efforts to push fluids, Mable is drinking just enough water to take her antibiotic. Mabel's arms are contracted, she has very fragile veins; an IV is not feasible. Dehydration is the most common fluid and electrolyte disorder among long-term care residents, and if left untreated in the elderly, serious complications, including death, can occur. In order to prevent Mable from a hospital readmission, she needs another hydration option.

Hypodermoclysis (HDC) is the non-IV hydration solution to restore fluid balance and a very safe, easy, effective, and cost-saving means of hydration.

Mable's physician is contacted to obtain HDC orders. What is HDC? It is the administration of isotonic fluids into the subcutaneous space to prevent dehydration or to restore hydration. The rate of absorption is nearly as rapid as the IV route and solutions can even be infused up to a combined total of 125 mL/hour with two separate sites. There are many advantages to HDC including less pain and more comfortable infusions for your residents. Initiation of HDC takes about 10% the time required to initiate IV hydration. Insertion is easy to learn. Many areas of the body can be used as a site, a variety of solutions can be infused, and specialized two sites combined, easy-to-use HDC sets are available.

INDICATIONS:

- Prevention of dehydration
- Mild to moderate dehydration
- Residents with active fluid loss
- Dysphagia
- Confusion
- Fluid requirements less than or equal to 3 liters/day
- Hydration prior to initiating venous access
- Limited venous access/need for repeated re-starts due to fragile veins
- Palliative care

SOLUTIONS (should be isotonic):

- 0.9%NS
- 0.2%NS, 0.45%NS with or without Dextrose 2.5 -5%
- Lactated Ringers (LR), Ringers
- Should not infuse dextrose solutions alone (due to rapid absorption of the dextrose, leaving sterile water, which by itself is hypotonic and would worsen the dehydration)

SITE LOCATIONS:

- Posterior, upper arms
- Infraclavicular/upper chest - avoid breast tissue
- Abdomen - at least 2" from navel
- Anterior or lateral thigh
- Upper back below scapula
- Flank area in some residents

Mable responds well to HDC and within 48 hours has started drinking fluids and feels better, and a hospital readmission was averted. There is no need to wait until our residents are dehydrated to initiate HDC. If your resident is refusing fluids, instead of "pushing fluids," contact the prescriber for HDC orders to restore fluid balance and prevent dehydration and a hospital readmission for your resident.

Remedi's consultant pharmacists and nurses are available to answer your questions and provide more information regarding HDC.

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Keeping Up with Anticoagulants

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Recognizing the importance of appropriate management of our residents on antithrombotic therapy is vital to providing excellent care. For more information, please contact your Remedi pharmacist.

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Eliquis [package insert]. Princeton, NJ: Bristol-Myers Squibb Co; 2014.

Zontivity [package insert]. Whitehouse Station, NJ: Merck & Co., Inc.; 2014.

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What Are Anticoagulants and Antiplatelet Agents? Dallas: American Heart Association, 2012. Answers by Heart Fact Sheets. Web. 29 Dec. 2014. <https://www.heart.org/idc/groups/heart-public/@wcm/@hcm/documents/downloadable/ucm_300338.pdf>.

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- **F327 (Hydration):** Fluid and electrolyte imbalance is a common cause of hospitalizations in the elderly. Accurate and on-going monitoring of a resident's fluid status is necessary, but relying on documented intake is neither required by regulation, nor particularly useful due to concerns regarding the accuracy of such documentation. Weighing a resident frequently can provide a more object measurement of their hydration status and allow for initiation of interventions well before clinical signs of dehydration appear. Straightforward approaches, such as reducing or discontinuing a diuretic when a resident's intake declines or anticipating and promptly responding to conditions known to negatively impact fluid intake (e.g., infections), can stabilize a resident and prevent the need for hospitalization.
- **F329 (Unnecessary Medications):** In the OIG study, medication-induced delirium or other change in mental status was one of the most commonly identified adverse events. For a detailed discussion of F329, please see the September 2014 issue of the Pulse (http://www.remedirx.com/media/55362/remedi-newsletter-september2014-email.pdf)
- **F441 (Infection Control):** The esteemed physician, Sir William Osler, described pneumonia as "the old man's friend," a reference to how lethal the disease was in the compromised elderly. Today, infections remain a significant cause of hospitalizations and facilities are required to develop and institute a comprehensive infection control program. Various aspects of F441 were reviewed in the November 2014 issue of the Pulse (http://www.remedirx.com/media/56994/remedi-newsletter-nov2014-web-version.pdf)
- **F155 (Advance Care Planning):** How many times should a resident with advanced dementia be hospitalized for treatment of recurring dehydration? How many ICU admissions, including ventilator support, should a resident with end-stage COPD endure? The answers to these questions typically come from residents themselves or, if they are not competent, a surrogate decision maker. Facilities have a regulatory obligation to fully inform residents of their overall health status, which certainly includes the risks and benefits associated with hospitalizations. By simply partnering with and supporting the decisions of residents and surrogate decision makers, unnecessary hospitalizations can be reduced.

As you work to eliminate preventable errors and resulting hospitalizations, please know that the full clinical and operational resources of Remedi SeniorCare are at your disposal.

Note: Bill was a surveyor with the Maryland State Survey Agency from 1988 until 2001. He became Chief Nurse of the agency in 2001 and remained in that position until joining Remedi SeniorCare in 2013.

[1] Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries (OEI-06-11-00370).

Nurse of the Month

NANCY TENNEY, LPN, CDP, CDCM, Director of Dementia Care Unit, Heather Hill Care Communities Chardon, Ohio

CONGRATULATIONS to Nanci Tenney, LPN, CDP, CDCM, Director of Dementia Care Unit, from Heather Hill Care Communities in Chardon, Ohio, for being chosen as the Remedi "Nurse of the Month." Nanci was nominated by Lisa Deering RN, MSN, CRRN, BC, LNHA, Director of Hospital and Long-Term Care Services, Heather Hill Care Communities. Per Lisa, "Nanci has been with Heather Hill for almost 3 years and has demonstrated all of the qualities one would want in a nurse. With over 37 years in the healthcare industry, she exemplifies compassion, altruism, and expertise. She is a Certified Dementia Practitioner and Certified Dementia Care Manager. She has planned, organized, opened, and maximized occupancy on two secured Memory Care units on our campus. She was nominated as committee chair this year by the Alzheimer's Association for the National Walk to End Alzheimer's, and she also serves as our facility hospice liaison. Nanci analyzes all drug regimes in the areas of antipsychotic and psychotropic medication use, monitors all reduction attempts, and coordinates psychiatric services throughout the campus. She is a valued, committed employee and leader in our organization, and we are fortunate to have her on our team! She is most deserving of recognition for all of her accomplishments!"

Remedi acknowledges a "Nurse of the Month" in each of our newsletters. DONs/ADONs/LNHAs, NOW is the time for you to reward the nurse(s) at your facility, who exemplify excellence in nursing practice. The "Nurse of the Month" will receive an award and a certificate of commendation from Remedi. Please submit the following information: nominated nurse's name/title, facility name, state, years at facility, years of experience and why this nurse should be chosen, such as leadership abilities, clinical expertise, teamwork, professional and personal strengths.

Email your Nurse of the Month nomination(s) by the 30th of the month to Rebecca.Ogden@RemediRx.com. Nurses Rock!!