

# the Remedi Pulse

PERSON-  
CENTERED CARE  
MED PASS



A CLINICAL AND REGULATORY UPDATE FROM REMEDI SENIORCARE

SUMMER 2017

## Survey Solutions

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

### The Dawning of a New Regulatory Day: Person-Centered Care

For many years, advocates of nursing home residents have rallied around the concept of culture change. They pushed hard for regulatory language that would not only encourage person-centered care, but actually require it. With the implementation of the 2016 federal Reform of Requirements for Long-Term Care Facilities (aka the mega-rule), that day has come. Not only is person-centered care now defined and referenced in multiple regulations, CMS indicated that it was an “over-arching principle”<sup>1</sup> that drove the entire regulatory reform process. Going forward, facilities that embrace person-centered care should be rewarded with fewer deficiencies and a reduced risk of higher level citations.

Medication management will not escape this heightened focus on person-centered care. Facilities should review the following concepts to determine if and to what degree their current practices comport with the tenets of person-centered care:

**Definition:** Current language under F tag 150 (reserved exclusively for definitions) now contains the following:

“... person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”

Does this mean that nursing home providers are deficient if they fail to comply with a resident’s demand for an antibiotic to treat a viral illness? Of course not ... in fact, pacifying the resident and administering the antibiotic would likely result in a deficiency being cited under F329 and/or the phase 2 regulations related to antibiotic stewardship. The primary take away from this definition is that residents, and if they lack capacity their surrogates, are to be consistently afforded the opportunity to

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#### EDITORIAL STAFF

JENNIFER HARDESTY Pharm.D., FASCP  
Chief Clinical Officer  
[Jennifer.Hardesty@RemediRx.com](mailto:Jennifer.Hardesty@RemediRx.com)

ROB SHULMAN BS, R.Ph., CGP, FASCP  
Director of Consultant Pharmacy Services  
[Rob.Shulman@RemediRx.com](mailto:Rob.Shulman@RemediRx.com)

REBECCA OGDEN BSN, RN, CRNI  
Corporate Account Manager  
[Rebecca.Ogden@RemediRx.com](mailto:Rebecca.Ogden@RemediRx.com)

Please do not hesitate to contact your Remedi Consultant Pharmacist or Account Manager if you have any questions or concerns.



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*“Going forward, facilities that embrace person-centered care should be rewarded with fewer deficiencies and a reduced risk of higher level citations.”*

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# Stop the Madness: Rational Medication Administration Times

Prepared by: Jennifer Hardesty, Pharm.D., Chief Clinical Officer

The seemingly endless medpass cycle—starting early at 6 a.m. and often going until midnight, can be challenging to both residents and staff alike! Numerous medication passes can tie up facility staff, and adversely affect resident quality of life by producing interruptions of activities and disrupting important sleep time. By promoting a person-centered, rational medpass schedule, individual preferences and quality of life can be preserved while still achieving good clinical outcomes.

## THE EARLY MORNING MEDICATION PASS

Several medications have traditionally been administered very early in the morning. Synthroid, Proton Pump Inhibitors, and Bisphosphonates (alendronate, risedronate), are often scheduled anywhere from 6 a.m. - 8 a.m., but these administration times may require staff to wake a resident early, just to take a medication. For those residents who prefer to sleep in, or are more challenging in the morning - consider these options:

### Proton Pump Inhibitors

- Some medications in this class may be given without regard to food (e.g., pantoprazole and rabeprazole)
- For certain residents, you may want to consider administering the drug 30-60 minutes prior to lunch or dinner to achieve an empty stomach, as opposed to breakfast
- Give medication with breakfast, but monitor efficacy closely for several weeks

### Synthroid

- While Synthroid is best absorbed on an empty stomach, it can be administered any time of day, as long as it is given under the same conditions each day
- For example, it can be given with breakfast, as long as it is always given with breakfast
- Alternatively, administer Synthroid 30 minutes prior to dinner, or at bedtime, to achieve the empty stomach condition

### Bisphosphonates

- Medications, such as alendronate or risedronate, should always be given on an empty stomach in the morning with a full glass of water, and the resident sitting upright to avoid adverse GI effects
- Administration time of this class of medication is not flexible; however, an extended-release risedronate (Atelvia) can be given immediately after breakfast
- Change resident to a once-weekly or once-monthly formulation

## THE “HEAVY” MEDICATION PASS

The heaviest medication pass of the day is traditionally the time that is assigned to “Once Daily” in your facility. Blood pressure medications, stool softeners, vitamins/minerals, cholesterol medications, antidepressants -- most of the “QD” medications are slated for this medpass. Staff often times have so many medications to administer and document that they run behind or may be tempted to take shortcuts; and residents have numerous medications to swallow. Consider “re-balancing” the medpass by doing the following:

- Move vitamin, mineral, and herbal supplements to a medpass later in the day
- Consolidate various vitamin and mineral supplements into a single product
- Administer docusate or other routine bowel medications at a later medpass

## LATE NIGHT MEDICATION PASS

As a general rule of thumb, you should re-evaluate the rationale of any routine medication order administered after 9 p.m. In certain circumstances a strict dosing schedule may be required (e.g., Parkinson’s Disease, pain management, antibiotics, etc.). A risk-vs.-benefit assessment should be performed for any medication therapy that may interrupt or impede a resident’s sleep. Those artificial tears Q2H can wait until morning!

## A FINAL NOTE:

If you choose to alter the administration time away from the standard, consider a statement in the resident’s record such as, *“I have evaluated the risk-vs.-benefit of administering DRUGXYZ at 6 a.m., and determined resident quality of life may be impacted adversely by waking him/her too early. Please administer the medication at 8 a.m.”* By doing what is best for the resident and documenting your rationale, you ensure good clinical care with transparent justification.

# Educational Resources for Tech-Savvy Residents and Healthcare Providers

Prepared by: Charlotte Lopacki, R.Ph., CGP, Clinical Consultant Pharmacist

As the broad wave of tech-savvy baby boomers continues to reach long-term care facilities, the availability of electronic drug information is a necessity. These residents desire to self-educate about their conditions and treatments and are looking for information via electronic avenues. As a health-care provider, it can be very helpful to have a “go to” website with accurate and reliable information that is easy to understand.

## The NIH National Library of Medicine provides a global medical information website at <https://www.nih.gov>

- **Medline Plus** at <https://medlineplus.gov/> can be used by medical professionals and the lay person to find up-to-date information on various disease states and the drugs used to treat them
- **Clear Health** from NIH has an extensive library of diseases states and conditions: <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/clear-health-nih>
- **Daily Med** <https://dailymed.nlm.nih.gov/dailymed/> provides package insert information for medications and patient education/instruction

## The FDA provides quick access to Medication Guides for the lay person at <https://www.fda.gov/drugs/resourcesforyou/consumers/>

- Similar to the patient education leaflets that are provided with prescriptions at retail drug stores, **Medication Guides** address issues that are specific to particular drugs and drug classes

**Organizational websites provide detailed disease-specific information and are a great source for up-to-date research information, white papers, and patient support groups.**

**Below are some examples:**

- Alzheimer's: **The Alzheimer's Association:** [www.alz.org](http://www.alz.org)
- Cancer: **The American Cancer Society:** [www.cancer.org](http://www.cancer.org)
- Diabetes: **The American Diabetes Association:** [www.diabetes.org](http://www.diabetes.org)
- Parkinson's: **National Parkinson Foundation:** [www.parkinson.org](http://www.parkinson.org); [www.michaeljfox.org](http://www.michaeljfox.org)

**Apps for smartphones can provide quick access to drug information for free or a minimal charge:**

- Drugs.com
- Epocrates
- Medscape
- Micromedex
- Pocket Pharmacist

## MyRemedi

- For times when hard-copy drug information is needed, Clinical Pharmacology can be accessed via the MyRemedi web portal at <http://www.remedirx.com>, to print drug specific patient education leaflets for discharge planning, or leave of absence events

There are numerous resources available to educate residents and their families regarding medication use. Finding resources that are readily accessible, trustworthy, and easy to navigate will make providing drug information a less complicated process. Your consultant pharmacist is another great resource and can provide or help guide you to the best resource to meet your needs. Please contact your reliable Remedi SeniorCare Consultant Pharmacist with any drug information questions you may have. We are ready to help in any way we can.

# Remedi Superstar Nurse

KELLY BEATTY, RN, DON  
Carington Park, Ashtabula, OH



**CONGRATULATIONS** to Kelly Beatty, RN, DON at Carington Park in Ashtabula, OH, for being chosen as the Remedi Superstar Nurse. Kelly was nominated by Molly Woodin RN, Admissions Nurse Liaison, and the Carington Park team. Per Molly, “Kelly Beatty has dedicated her nursing career of 19 years to making Carington Park a better place for our residents to live and for our employees to work. Her can-do attitude motivates many nurses to go above and beyond to provide the special care that our residents receive. Kelly takes into consideration everyone’s opinion and ideas for problem-solving throughout the facility. She is very professional and thinks outside the box to promote great nursing and person-centered care. Kelly treats everyone the same and is a fair boss. She works very hard at quality improvement programs including nursing, medical care, dietary, and home improvement programs. Kelly is a great leader and inspires us all to be BETTER nurses.”

Email your Superstar Nurse nomination(s) to [Rebecca.Ogden@RemediRx.com](mailto:Rebecca.Ogden@RemediRx.com)

## Survey Solutions

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be active participants in all aspects of their care.

**Informed Consent:** F tag 154 (Planning/Implementing Care) now contains additional elements which are particularly relevant to medication management:

“The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.”

Each time a prescriber gives a telephone order for a medication, does the nurse then have a discussion with the resident that addresses the components listed above before administering the first dose? Would every nurse have the knowledge base to competently have such a discussion? Does this regulation apply to all medications (e.g., multivitamins) or just high risk ones like anticoagulants? And what about documentation ... how much and what type (e.g., signed consent forms) is enough to demonstrate compliance with this regulation? As resident engagement and choice are the cornerstones of person-centered care, perhaps a QAPI project that evaluates the processes currently surrounding the initiation of medications would be a productive use of a facility’s resources.

**Care Planning:** The term person-centered care is now part of the actual regulation at F tag 280 along with other important new requirements:

“The right to participate in the development and implementation of his or her person-centered plan of care ...”

“The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.”

“The right to receive the services and/or items included in the plan of care.”

How medications are managed (vital sign monitoring, drug administration during dialysis visits, etc.), identification of commonly occurring adverse drug reactions, and goals of medication therapy (normalization of blood pressure, improvement in depressive symptoms, etc.), are all memorialized in a resident’s plan of care. F280 appears to elevate the plan of care to a contract between the resident and the facility with the failure to deliver the agreed upon services now clearly deficient.

The above represents just the tip of the iceberg when it comes to person-centered care and CMS regulations. It is specifically referenced in regulatory language related to pain management, dialysis, ostomy care, parenteral fluids, respiratory care, and prostheses. As facilities develop new policies and protocols mandated by the mega-rule, they would be wise to incorporate principles of person-centered care. Surveyors will no doubt be highly influenced by the presence or absence of person-centered care practices and related staff behaviors during each and every survey.

<sup>1</sup><https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

*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.*