CALTCM 2014

Innovation to Action

Care of Wounds, Dementia and COPD

Promoting quality patient care through medical leadership and education

May 2-3, 2014

Omni Los Angeles Hotel at California Plaza
Los Angeles, CA

CALTCM
California Association of Long Term Care Medicine

Program Introduction

2014 is the year of QAPI (Quality Assurance Performance Improvement) implementation throughout our country. With that in mind, we have designed our meeting for practical training for key players in your facility in areas where LTC has struggled to improve quality. To help you implement QAPI, we have designed innovative case-based half-day workshops for your facility (or virtual facility) designed to help you put this new knowledge into constructive and sustainable action for the benefit of your patients.

We have purposely chosen the care of Wounds and Dementia, since these are areas where prior quality efforts have often had disappointing results. To facilitate interactive learning, we have chosen a round table format for all of our workshops.

In addition, knowing that our hospital partners are being penalized for early relapse of COPD patients, we bring to you advances in COPD care focused on reducing the 30 day relapse rate through integrated care models.

We anticipate another delightful Poster session where we will not only learn from organized presentations on facility innovation, but also have opportunities to discuss the project with the author(s).

An additional highlight will be the collegial working relationships that develop around the tables at our annual meeting.

Bring your team, enjoy the interactive learning, and return home reinvigorated for with actions that fulfill the QAPI mandates.

Program Learning Objectives

1. The participant will develop QAPI skills that they will then implement in specific action plans in their facilities;

2. The participant will identify at least 3 QAPI performance improvement projects for implementation in the coming year;

3. The participant will better understand models of improving care integration, the incentives for improving this care, and then make specific decisions about how they will improve care integration in their facilities.

CALTCM Annual Meeting Accreditation Statement

Continuing Medical Education (CME)

The California Association of Long Term Care Medicine (CALTCM) is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

The California Association of Long Term Care Medicine (CALTCM) designates this Live activity for a maximum of 10 *AMA PRA Category 1 Credit(s)™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.
This course complies with Assembly Bill 1195 Continuing Education: Cultural and Linguistic Competency.

American Academy of Family Physicians (AAFP)

This live activity, CALTCM 40th Annual Meeting: Innovation to Action: Care of Wounds, Dementia, and COPD, with a beginning date of May 2, 2014, has been reviewed and is acceptable for up to 10 Prescribed credits by the American Academy of Family Physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Board of Registered Nursing (BRN)

SCAN Health Plan® is a provider approved by the California Board of Registered Nursing (Provider #CEP-13453). This activity has been approved for up to 10 contact hours.

California Board of Behavioral Sciences (BBS)

Course meets the qualifications for 10 hours of continuing education credit for MFT's and/or LCSW's as Required by the California Board of Behavioral Sciences (BBS). California Association of Long Term Care Medicine (CALTCM) BBS Provider No. PCE-3077.

American Medical Directors Certification Program (AMDCP)

This course has been approved for up to 1.75 credit hours of clinical education and 8.25 credit hours of Management education toward certification or recertification as a Certified Medical Director in Long Term Care (AMDA CMD). The AMDA CMD program is administered by the American Medical Directors Certification Program (AMDCP). Each physician should claim only those hours actually spent on the activity.

Nursing Home Administrators Program (NHAP)

CALTCM Annual Meeting: Dementia Workshop has been approved by the Nursing Home Administrator Program for up to 4.0 hours of NHAP credit. Course approval number: 1699004-4399/P
CALTCM Annual Meeting: QAPI Workshop has been approved by the Nursing Home Administrator Program for up to 3.0 hours of NHAP credit. Course approval number: 1699003-4403/P
CALTCM Annual Meeting: COPD Workshop has been approved by the Nursing Home Administrator Program for up to 3.0 hours of NHAP credit. Course approval number: 1699003-4404/P

Continuing Pharmaceutical Education

SCAN Health Plan® is accredited by the California Accreditation of Pharmacy Education (CAPE) as a provider of continuing pharmacy education. Pharmacists completing this course on 5/2/2014-5/3/2014 will receive up to 10.00 hours of credit through SCAN Health Plan® (CAPE Provider #199). CEU credits are also accepted by the Pharmacy Technician Certification Board (PTCB) to meet re-certification requirements (please retain program brochure and the certificate in event of an audit).

This course meets multiple requirements of the California Business and professions Codes 2190–2196.5 for physician CME, including cultural competency and geriatric credits.

Special Acknowledgements

CALTCM would like to extend our gratitude to all our sponsors

This program is supported in part by co-sponsorships from

American Society of Consultant Pharmacists—California Chapter
SCAN Health Plan®

Additional Co-Sponsorships

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Jennifer Wieckowski, MSG

Program Faculty

Debra Bakerjian, PhD, RN, FNP
Vice Chair for FNP/PA Studies, Department of Family and Community Medicine, Assistant Adjunct Professor, Betty Irene Moore School of Nursing University of California, Davis

Mary Ellen Dellefield, PhD
Researcher, VA San Diego Healthcare System

Shawkat Dhanani, MD, MPH
Associate Chief of Staff, Geriatrics & Extended Care Director, Geriatric Evaluation & Management Unit, VA Greater Los Angeles Healthcare System Clinical Professor of Medicine, UCLA

David Farrell, MSW, LNHA
Senior Director, The Green House Project

Rebecca C. Ferrini, MD, MPH, CMD
Medical Director, Edgemoor Hospital, Santee, CA, Co-Chair, CALTCM Education Committee

Timothy Gieseke, MD, CMD
Multi-Facility Medical Director, Santa Rosa, CA; Associate Clinical Professor, University of California, San Francisco; Chair, CALTCM Education Committee

Janice Hoffman, Pharm.D., CGP, FASCP
Professor of Pharmacy Practice and Administration, Western University of Health Sciences, College of Pharmacy

Program Faculty (continued)

Jim Jordan
Administrator, Asbury Park Nursing and Rehab

Wendy Liu, RN
Registered Nurse, Edgemoor Hospital

Ken Lund
President and CEO Kennon S. Shea & Associates

James Mittelberger, MD, MPH, CMD, FACP
Chief Medical Officer, Evercare Hospice and Palliative Care/Optum, CALTCM President

Dan Osterweil, MD, FACP, CMD
Vice President/Medical Director, SCAN Health Plan; Founder of S+AGE program in Sherman Oaks; Immediate Past President of CALTCM; Associate Director and Clinical Professor in the Multicampus Program in Geriatrics and Gerontology at the UCLA David Geffen School of Medicine

Karl E. Steinberg, MD, CMD
Medical Director, Kindred Village Square Transitional Care & Rehabilitation Center, San Marcos, CA; Medical Director, Life Care Center of Vista, Vista, CA; Editor-in-Chief, Caring for the Ages; Vice Chair, AMDA Public Policy Committee; Vice President, Coalition for Compassionate Care of California, CALTCM Secretary

Jennifer Wieckowski, MSG
Program Director, Care Transitions, Health Services Advisory Group of California, Inc.

Faculty Bios

Debra Bakerjian, PhD, FNP, RN, FAANP

Senior Director for Nurse Practitioner and Physician Assistant Clinical Education and Practice
Assistant Adjunct Professor

Debra Bakerjian is senior director for nurse practitioner and physician assistant clinical education and practice, as well as an assistant adjunct professor, at the Betty Irene Moore School of Nursing at UC Davis. Previously, Bakerjian was a Betty Irene Moore School of Nursing Postdoctoral Fellow with specialties in health policy and system change.

Bakerjian's research aims to maximize the role of advanced practice nursing and improve the quality of care for aging populations. Her research focuses on the role of nurse practitioners and physician assistants; patient safety and quality improvement practices in long-term care, particularly nursing homes; care transitions between acute-care facilities, nursing homes and assisted living centers; pressure ulcer prevention and management; pain management; chronic disease management in frail older adults; and interprofessional education and practice.

Bakerjian was a Pat Archbold Predoctoral Scholar and a Claire M. Fagin Postdoctoral Fellow at UC San Francisco in the Department of Social and Behavioral Sciences, where she was also an assistant adjunct professor. She earned a Doctor of Philosophy in Health Policy and Gerontology in 2006 and a Master in Science of Nursing in 1992, both from UC San Francisco School of Nursing. Her doctoral study, "Utilization of Nurse Practitioners in Nursing Homes: A Comparison with Physicians," received the 2006 Dissertation of the Year Award at UC San Francisco. Bakerjian earned a Family Nurse Practitioner and Physician Assistant certificate from the UC Davis School of Medicine in 1991 and a Bachelor of Science in Health Services Administration from the University of Phoenix in 1983. She received an Associate Degree in Nursing from Evergreen Valley College in San Jose, Calif., in 1977.

Bakerjian is active in both state and national organizations associated with the care of older adults. She serves on the board of directors for Advancing Excellence in American Nursing Homes' and on the National Quality Forum's Skilled Nursing Facility Technical Expert Panel for Serious Reportable Events and Common Formats. She is on the Health Sciences Executive Committee of the Gerontological Society of America and the Quality Measures Committee for the American Geriatrics Society. She is also chair of the Nursing Home Special Interest Group and past president of the Gerontological Advanced Practice Nurses Association and current president of the Gerontological Advanced Practice Nurses Association Foundation. She serves on the executive committee and is the incoming president of the California Association of Long Term Care Medicine. She is also a member of the advisory committee for the American Medical Director's Association Clinical Practice Guidelines.

Contact Information: Phone: (916) 734-2145 | E-mail: Debra.Bakerjian@ucdmc.ucdavis.edu

Faculty Bios

Mary Ellen Dellefield, PhD, RN

Mary Ellen Dellefield, PhD, RN is a Research Nurse Scientist at VA San Diego Healthcare System. She is a Clinical Professor at the Hahn School of Nursing and Health Sciences in San Diego, California and a Hartford Gerontological Nurse Leader. Dr. Dellefield has worked as a Director of Nursing, Director of Staff Development, Infection Control Nurse, staff nurse, and Minimum Data Set Nurse Coordinator over the past 25 years in San Diego county nursing homes. Her research area of interest includes pressure ulcer prevention in nursing homes, registered nurse practice in nursing homes, evidence-based practice, and the care planning process. Dr. Dellefield has written numerous articles in peer reviewed journals and book chapters.

Shawkat Dhanani, MD

Dr. Dhanani is a Clinical Professor of Medicine at UCLA and Associate Chief of Staff for Geriatrics and Extended Care at the VA Greater Los Angeles Healthcare System.

He is also the Director of Geriatric Evaluation & Management Unit at the VA Greater Los Angeles Healthcare System and is fellowship trained in both Geriatric and Pulmonary Medicine.

David Farrell, MSW, LNHA

David Farrell, M.S.W., L.N.H.A., is a licensed nursing home administrator who has spent his entire career in the long-term care profession. He started as a certified nursing assistant in order to earn extra money while attending college. That experience inspired him to pursue a Master's degree in Social Work with a concentration in Gerontology and Administration from Boston College. In the 25 years he has served as a nursing home administrator and regional director of operations, David has advocated for patient-centered care using quality improvement practices. A published author and member of the Board of Directors at the Pioneer Network, his award winning book, “Meeting the Leadership Challenge in LTC: What You Do Matters!" co-authored with Barbara Frank and Cathie Brady, has received widespread acclaim. Currently, David is the Senior Director of The GREEN HOUSE Project where he helps spread the evidence-based Green House Model across the U.S.

Faculty Bios

Rebecca Ferrini, MD, MPH, CMD

Medical Director, Edgemoor DP SNF

Rebecca L. Ferrini, MD, MPH, CMD is the full-time medical director of Edgemoor Hospital DP SNF in Santee, California, a government run 192-bed facility which cares for a younger long-term care population with extensive physical, psychosocial and psychiatric challenges. She was honored in 2009 as the AMDA Medical Director of the Year for her role in improving the quality of care at the facility. She has special interest in consent and capacity, Huntington's Disease, and behavioral management.

Timothy Gieseke, MD, CMD

Dr. Gieseke graduated AOA from UCI in 1076 and then completed a straight Internal Medicine at UCD, Sacramento Medical Center. Since 1979, he has practiced internal medicine in Santa Rosa with an emphasis on gerontology and palliative care. He left his office practice in 2005 to focus full time on LTC medicine. He teaches LTC medicine at the Sonoma County UCSF affiliated Family Medicine Residency where he is an Associate Clinical Professor. He is a past Associate Medical Director for Sutter VNA Hospice. He is a CMD and has been a Medical Director of CCRC since 1986 and is currently a Medical Director for 4 other SNFs.

He was President of CALTCM (California Association of Long Term Care Medicine) July 2005-2007, and is the Chairperson of the Education committee since last May and was the Chair from July 2008 to July 2010. He is a member of the POLST physician leadership council and was a member of the state taskforce for developing the CARE recommendations for LTC. CARE stands for Compassion and Respect at the End of Life. He has presented on Culture Change, the POLST, the CARE Recommendations, and Diabetes care at CALTCM annual meetings and the POLST/CARE at AMDA annual meetings. He has been involved in CARE Transition projects in Sonoma County and has been a faculty participant in INTERACT workshops and subsequent implementation projects.

He has been interested in international medicine since participating in a medical project in Ecuador in 1990. He subsequently has been a participant on 16 medical educational projects in Albania and 2 in Pristina, Kosovo.

Faculty Bios

Janice Hoffman, PHARM.D. CGP, FASCP

Dr. Janice Hoffman is a Certified Geriatric Pharmacist and a Fellow of the American Society of Consultant Pharmacist. She is an Associate Professor of Pharmacy Practice and Administration for Western University of Health Sciences and her clinical practice sites are S+AGE clinic and at Jewish Home for the Aging where she is a clinical consultant. She received her Pharm.D. from the University of Southern California and completed a specialty Residency in Clinical/Administrative Psychiatric Pharmacy Practice with an emphasis in geriatrics from the University of Maryland at Baltimore. She is currently President for the American Society of Consultant Pharmacists – California Chapter and on the Board of Directors for the Academy of Long-Term Care Pharmacists as well as the Editorial Review Committee for the California Pharmacists Association. Her areas of interest and research include: geriatric psychiatry, interdisciplinary health care teams and complementary herbal medications.

James Jordan

Administrator, Asbury Park Nursing & Rehab

Wendy Liu, RN, BSN, PHN

Wendy Liu is a Registered Nurse at Edgemoor Skilled Nursing Facility in Santee, California. Ms. Liu has worked in long-term care facilities for four years, and she loves to work with the geriatric population. Her passion in helping the elderly stemmed from living and caring for her grandparents while she was a child.

Born in China, her family immigrated to the United States in 1990. Ms. Liu was raised in the City of Alhambra in the Los Angeles Area. Ms. Liu's education includes undergraduate degrees in Biochemistry from UCLA and Nursing from Azusa Pacific University, and a Master's degree in Biochemistry from Cal State Los Angeles. Her hobbies include eating out with her husband, watching Chinese dramas, and visiting social media websites on the internet. Ms. Liu's goals are to strengthen and utilize her skills in challenging positions which will afford advancement and professional growth.

Faculty Bios

Ken Lund, CEO

As CEO of Shea Family since 2010, Ken transitioned a traditional custodial based nursing company into a leading edge post-acute provider offering a single point of entry to a full array of services throughout the healthcare continuum. With over 30 years of experience in top management industries ranging from banking, real estate to nationwide distribution, Ken has spent the last decade revitalizing senior living and skilled nursing companies using a lifestyle and service based approach. Accomplishments have included: As CEO of Westlake Senior Living, increasing the market value from $50M to $120M in less than two years by changing their industry paradigm. Over the same period, occupancy rates climbed from 65% to 98% and customer satisfaction increased from 50% to 95%. While at Shea, he has repositioned the company into a true post-acute recovery continuum, by adding complementary businesses and support services that function as independent profit centers while enhancing continuity of care. Ken has a BBA in Finance and Human Resources from Pacific Lutheran University in Tacoma, WA.

James Mittelberger, MD, MPH, CMD

Dr. James Mittelberger MD MPH CMD FACP has 30 years of ongoing active clinical practice in the fields of Internal Medicine, Geriatric Medicine and Palliative Care and Hospice. He has over 20 years experience as Chief of a Division of Geriatrics and Palliative Care at the Alameda County Medical Center including specialty geriatrics & dementia clinics. clinical experiences include over 25 years as a nursing home medical director, physician home care, hospitalist medicine. Leadership and management roles have included health clinic medical director, medical staff president, President of Oakcare Medical Group, a multi-specialty medical group, Interim CEO of the Alameda County Medical Center, founding board member and Chair of the Board of the Alameda Alliance for Health and regional CMO for a United Healthcare's Medicare division. His training includes an MPH in health services, a faculty development fellowship in Clinical Ethics, and a CHCF leadership fellowship. He is currently national CMO of the Optum Palliative and Hospice Care and a Senior medical director for Optum as well as CALTCM President.

Faculty Bios

Dan Osterweil, MD, FACP, CMD

Dan Osterweil, MD, FACP, Msc Ed., CMD, Vice President/Medical Director, SCAN Health Plan and Professor of Medicine at UCLA, completed a geriatrics fellowship at UCLA. Dr. Osterweil is the founder of the Specialized Ambulatory Geriatric Evaluation (S+AGE™) Clinic, a community-based, geriatric assessment center in Sherman Oaks. He is the Emeritus-editor of the Journal of the American Medical Directors Association (JAMDA) in which he has founded. He is a member of the editorial board of Caring for the Ages. Dr. Osterweil co-authored two editions of *Medical Care in the Nursing Home*, is the co-editor of Comprehensive Geriatric Assessment, and has published over 60 articles in peer-reviewed journals. His areas of expertise include cognitive and functional assessment, management of dementia, and continuous quality improvement in the nursing home, planning and implementation of the work processes in the nursing home, in-depth knowledge of nursing home state and federal regulations, and practice innovations. Dr. Osterweil is Director of a UCLA training program entitled Leadership and Management in Geriatrics (LMG) and Associate Director of the Multicampus Program in Geriatrics and Gerontology at UCLA (MPGMG).

Karl Steinberg, MD, CMD

Dr. Karl Steinberg is an experienced clinician with over 20 years in practice in San Diego County. He is a geriatrician and board-certified family physician with a subspecialty certification in hospice and palliative medicine. He serves as chief medical officer for Shea Family Health, an El Cajon-based nursing home and post-acute care chain, medical director of two other skilled nursing facilities, Kindred Village Square and Life Care Center of Vista, and medical director of Hospice by the Sea in Solana Beach. Dr. Steinberg has been a nursing home medical director and hospice medical director since 1995 and is probably best known for taking his dogs on rounds with him almost every day.

Dr. Steinberg got his undergraduate degree in biochemistry and molecular biology from Harvard in 1980, then taught high school in New York City for three years. He attended medical school at The Ohio State University, graduating in 1987, then completed his family medicine residency at UCSD in 1990. Dr. Steinberg serves as voluntary faculty and community preceptor for UCSD and Naval Hospital Camp Pendleton's family medicine residency programs as well as for Samuel Merritt's P.A. program, Point Loma Nazarene's Clinical Nurse Specialist program, and others. He also has an appointment as adjunct faculty for Case Western Reserve University's graduate school of biomedical engineering, where he teaches a course on the U.S. healthcare system.

(Dr. Steinberg's Bio is continued on the next page)

Faculty Bios

Karl Steinberg, MD, CMD (continued)

Dr. Steinberg is the Editor-in-Chief of *Caring for the Ages*, a monthly periodical with a print circulation of 25,000, on behalf of the American Medical Directors Association (AMDA). He is on AMDA's board of directors and serves as vice chair of AMDA's Public Policy Committee, as well as vice chair of the Compassionate Care Coalition of California. He is secretary and past president of the California Association of Long Term Care Medicine (the California chapter of AMDA, called CALTCM). Dr. Steinberg is also CEO of Stone Mountain Medical Associates, Inc., a consulting company, and serves as an expert consultant in legal, regulatory, quality and risk management matters.

Among Dr. Steinberg's professional interests are advance care planning, palliative care, care transitions, dementia, depression, bioethics and addiction medicine. In his extensive spare time, Dr. Steinberg enjoys playing tennis and guitar, traveling, photography, hanging out with his dogs (including taking them on nursing home rounds), and running on a treadmill while playing Words With Friends and listening to classic rock.

Jennifer Wieckowski, MSG

Program Director, Care Transitions
Health Services Advisory Group

Jennifer Wieckowski currently serves as Program Director, Care Transitions, for Health Services Advisory Group of California, the Medicare Quality Improvement Organization. In this position, she is responsible for working with communities throughout California to improve care transitions across health care settings and reduce statewide readmissions. Her previous role at HSAG was the Director, Nursing Homes, Patient Safety in which she directed and implemented quality improvement activities with nursing homes throughout the state. Prior to joining HSAG, Ms. Wieckowski managed several federal Administration on Aging and National Council on Aging research projects of the California Health Innovation Center at Partners in Care Foundation investigating the delivery of evidence-based disease prevention programs throughout California. Jennifer's passion for the aging field began at the age of eleven when she began volunteering in adult day health care programs and nursing homes. After volunteering for seven summers at multiple healthcare settings, Jennifer pursued her Bachelor of Science Degree from Cornell University in Human Development and Family Studies, with a certificate in Gerontology, and her Master of Science Degree in Gerontology from the University of Southern California. She resides in Valencia, California with her husband, Kris, daughter Allison (age four) and twin 18 month olds, Nick and Kelly.

Faculty and Planner Disclosures

Notice of Incorrect Disclosure

At the CALTCM 40th Annual Meeting - Innovation to Action: Care of Wounds, Dementia, and COPD, presented on May 2 - 3, 2014, incorrect information appeared in the Faculty and Planner Disclosures, and in COPD Q&A Panel Discussion. These sections should have contained the following information: “Dr. Steinberg has received honoraria for being on the non-branded speakers bureau for Boehringer Ingelheim. No other faculty or planners have any relevant financial relationships with a commercial interest to disclose. Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.”

Faculty and Planner Disclosures

It is the policy of California Association of Long Term Care Medicine (CALTCM) to ensure balance, independence, objectivity, and scientific rigor in all of its sponsored educational programs. All faculty participating in any activities which are designated for *AMA PRA Category 1 Credit(s)* ™ are expected to disclose to the audience **any** real or apparent conflict(s) of interest that may have a direct bearing on the subject matter of the CME activity. This pertains to relationships with pharmaceutical companies, biomedical device manufacturers, or other corporations whose products or services are related to the subject matter of the presentation topic. The intent of this policy is not to prevent a speaker with a potential conflict of interest from making a presentation. It is merely intended that any potential conflict should be identified openly so that the listeners may form their own judgments about the presentation with the full disclosure of the facts. It remains for the audience to determine whether the speakers' outside interests may reflect a possible bias in either the exposition or the conclusions presented.

The following faculty and planners have indicated any affiliation with organizations which have interests related to the content of this conference. This is pointed out to you so that you may form your own judgments about the presentations with full disclosure of the facts. All conflicts of interest have been resolved in accordance with the ACCME's Standards for Commercial Support.

Faculty and Planners	Affiliation/Financial Interest	Name of Organization
Debra Bakerjian, PhD, RN, FNP	National Advisory Board Member National Quality Forum	Omnicare Pharmacy Common Formats
Joseph Bestic, NHA, BA	None	
Mira Cantrell, MD	None	
Jodi Cohn, Dr. P.H.	None	
Heather D'Adamo	None	

Faculty and Planners (Continued)	Affiliation/Financial Interest	Name of Organization
Mary Ellen Dellefield, PhD	None	
Shawkat Dhanani, MD, MPH	None	
David Farrell, MSW, LNHA	None	
Rebecca Ferrini, MD, MPH, CMD	None	
Timothy Gieseke, MD, CMD	None	
Janice Hoffman, Pharm.D, CGP, FASCP	Grant	Novartis
Barbara Hulz	None	
Ashkan Javaheri, MD, CMD	None	
Jim Jensen, MHA, MA	None	
James Jordon	None	
Wendy Liu, RN	None	
Ken Lund	None	
Renee McNally	None	
James Mittelberger, MD, MPH, CMD, FACP	None	
Sheryl Nespor, PhD, FNP	None	
Dan Osterweil, MD, FACP, CMD	None	
KJ Page, RN, NHA, ND	None	
Glenn Panzer, MD	None	
Rajneet Sekhon, MD	None	
Karl Steinberg, MD, CMD*	Non-Branded Speakers Bureau*	Boehringer Ingelheim*
Jennifer Wieckowski, MSG	None	

*REVISED JUNE 2014

Program Schedule – Friday May 2, 2014
QAPI: Care of Wounds

Moderator: Dan Osterweil, MD, FACP, CMD

11:00 a.m.	**Registration/Exhibits Open**
11:45 a.m.	**Industry Supported Lunch**
1:00 p.m.	**Welcome & Introductions -** James Mittelberger, MD, MPH, CMD, FACP
1:10 p.m.	**Opening Comments -** Timothy Gieseke, MD, CMD
1:15 p.m.	**QAPI Overview -** David J. Farrell, MSW, LNHA
1:45 p.m.	**Wound Diagnosis and Management - Workshop** **Wound Diagnosis and Management - Case Study Presentation** **Wound Diagnosis and Management - Small Group Discussion** Debra Bakerjian, PhD, RN, FNP, FAANP
2:30 p.m.	**Break**
3:00 p.m.	**Wound Diagnosis and Management - Interactive Lecture** Debra Bakerjian, PhD, RN, FNP, FAANP
3:40 p.m.	**Pressure Ulcer Prevention - Mary Ellen Dellefield, PhD**
4:00 p.m.	**Action Planning Session - Wound Care**
4:30 p.m.	**Q&A Panel Discussion - QAPI and Wound Care** Debra Bakerjian, PhD, RN, FNP, FAANP; Mary Ellen Dellefield, PhD; David J. Farrell, MSW, LNHA; James Jordan
5:30 p.m.	**CALTCM Update**
6:00 p.m.	**Poster Session & Reception | Exhibits Close**
7:00 p.m.	**Industry Sponsored Dinner**

Program Schedule – Saturday May 3, 2014
Care of the Difficult Dementia Patient

Moderator: James Mittelberger, MD, MPH, CMD, FACP

7:00 a.m.	**Exhibits Open**
7:00 a.m.	**Breakfast**
8:00 a.m.	**Welcome**
8:05 a.m.	**Care of the Difficult Dementia Patient Upon Admission** **Case Study** (Admission Presentation) **-** Timothy Gieseke, MD, CMD **Mock MDS Care Conference -** Wendy Liu, RN **Small Group Discussions -** Rebecca Ferrini, MD, MPH, CMD
9:00 a.m.	**Care Planning for Difficult Patients** Mary Ellen Dellefield, PhD
9:20 a.m.	**Break/Exhibits**
9:50 a.m.	**Reducing Inappropriate Antipsychotic Use in Dementia Care** Janice Hoffman, PharmD, CGP, FASCP
10:20 a.m.	**Difficult Dementia Cases, a Facility Specific Approach** Rebecca Ferrini, MD, MPH, CMD
11:00 a.m.	**Action Planning Session - Dementia Care**
11:25 a.m.	**Q&A Panel Discussion - Dementia Care** Mary Ellen Dellefield, PhD; Rebecca Ferrini, MD, MPH, CMD; Timothy Gieseke, MD, CMD; Janice Hoffman, Pharm.D., CGP, FASCP; Wendy Liu, RN

Program Schedule – Saturday May 3, 2014
Improving COPD Care in Long Term Care

Moderator: Karl E. Steinberg, MD, CMD

12:00 p.m.	**Exhibits**
12:00 p.m.	**Industry Supported Lunch**
1:00 p.m.	**CALTCM Awards**
1:30 p.m.	**Expanding Incentives to Improve Care** Jennifer Wieckowski, MSG
1:45 p.m.	**Improving COPD Care in Long Term Care** Timothy Gieseke, MD, CMD
2:05 p.m.	**COPD Care in Older Adults - Acute & Long Term Care Setting** Shawkat Dhanani, MD, MPH
2:45 p.m.	**Break/Exhibits**
3:15 p.m.	**Quality and Efficiency Care Model** Ken Lund
3:40 p.m.	**Green House Model for Post-Acute Care** David J. Farrell, MSW, LNHA
4:15 p.m.	**Action Planning Session - COPD**
4:40 p.m.	**Q&A Panel Discussion: COPD Care and Integrated Care Models** Shawkat Dhanani, MD, MPH; David J. Farrell, MSW, LNHA; Timothy Gieseke, MD, CMD; Ken Lund; Jennifer Wieckowski, MSG

QAPI:
Care of Wounds

Friday
May 2, 2014

QAPI – Quality Assurance / Performance Improvement

David Farrell, LNHA, MSW
Senior Director
The Green House Project

Disclosure Statement

- I have no relevant financial relationships with a commercial interest to disclose.

Learning Objectives

- Identify at least 1 of the 5 elements of QAPI that you will improve in your facility
- Define the role of the Medical Director in their quality improvement program
- Select a facility problem for further study, analysis, and targeted intervention(s) using metrics, PDSA cycle, and pilot processes
- Define next steps to insure that every employee will be involved in quality improvement in their facility
- Select specific AHRQ tools they will adapt to their facilities wound management program

How to Improve Providers' Performance

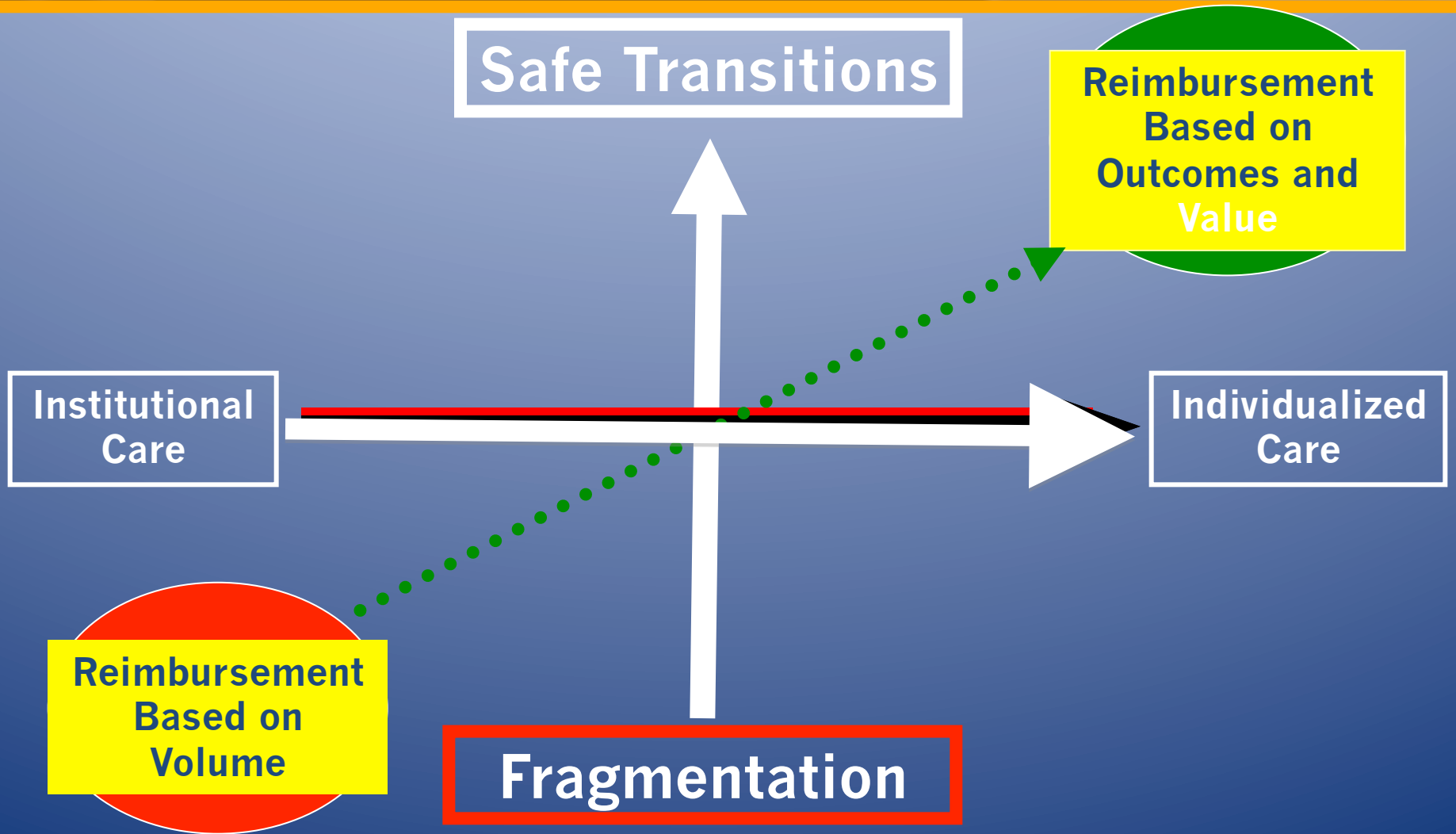
- Regulations
- Public reporting
- Reimbursement

ACA's Three Aims

- *Better patient experience*
- *Better outcomes*
- *Lower costs*

Medicare/Medicaid Become Managed Care

- Goal – encourage coordinated care
- Reward providers that meet three aims –
  - Safe, efficient transitions
  - Low rehospitalization rates
  - Excellent outcomes


Safe Transitions
Reimbursement Based on Outcomes and Value
Institutional Care
Individualized Care
Reimbursement Based on Volume
Fragmentation

Why QAPI?

- Affordable Care Act
- QAPI in other Federally certified programs
  - hospitals, transplant programs, dialysis centers, ambulatory care, hospice
- QAPI to be consistent with other settings
- Considers issues unique to NH setting

QAPI Development

- University of Minnesota with Stratis Health
- Activities include:
  - Demonstration project to test tools and resources
  - Technical Assistance & Learning Collaborative
  - On-Line Resource Library
  - Development of “best practices”
  - TEP to review and advise

Together = QAPI

Quality Assurance:

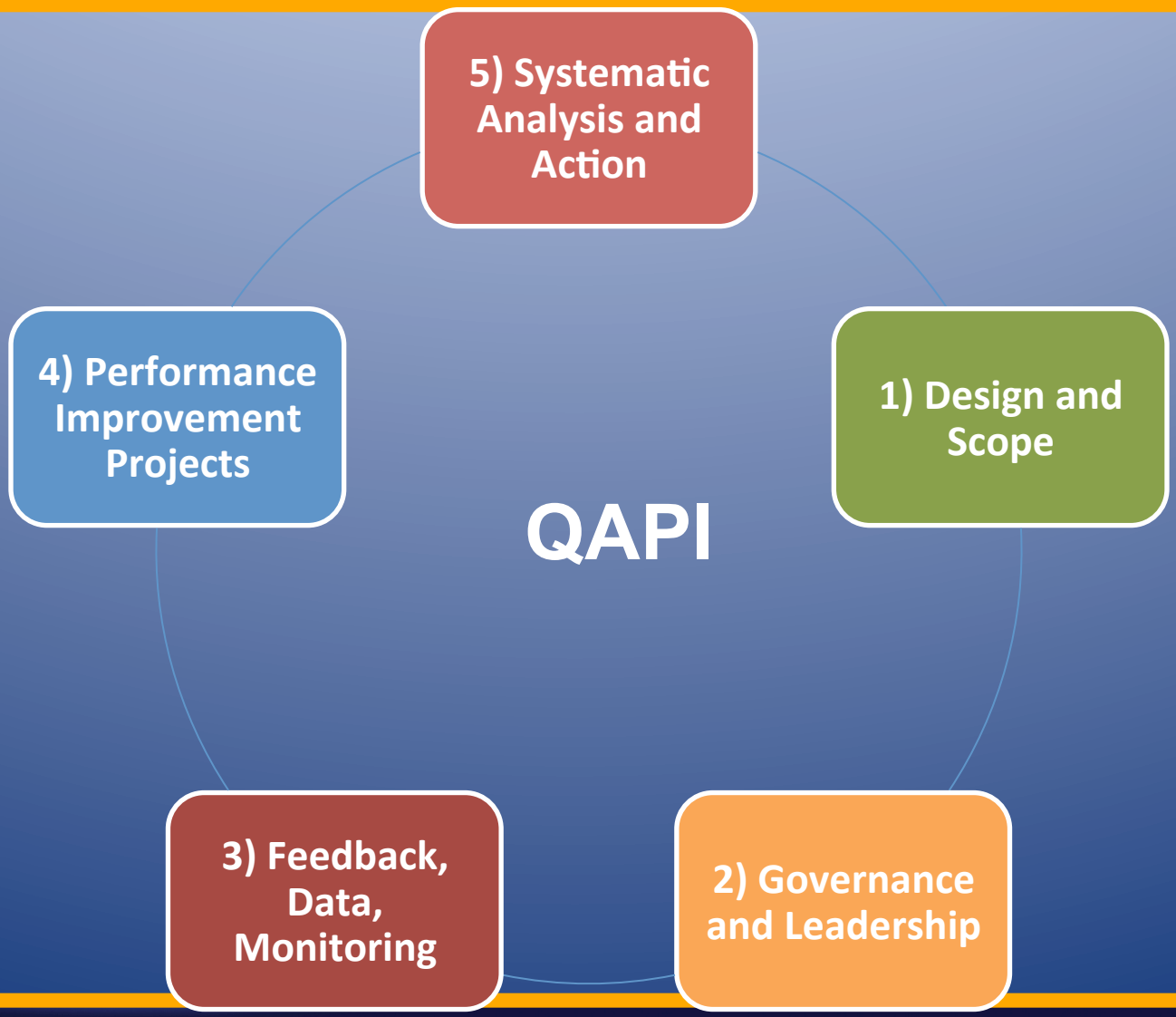
- Retrospective analysis
- Process to meet standards
- Limited involvement
- Driven by external forces
- Narrow focus on clinical measures
- Needed to stay licensed
- Regulations currently exist

Performance Improvement:

- Internal management process
- Proactive analysis designed to detect problems early
- Broad focus on organizational systems and outcomes
- High involvement
- Driven by quality leaders and their search for better ways
- Evidence-based leadership

Lanham, H., et al, 2009

5 Core Components



Design and Scope

Design and Scope

- Comprehensive, ongoing program
- Includes all departments
- Addresses –
  - Safety
  - Quality of life
  - Resident choice

Design and Scope

- Utilize best available evidence
  - National benchmarks
  - Evidence-based best practices
  - Clinical guidelines
- Measurable goals
- QAPI plan in compliance

Governance and Leadership

Governance and Leadership

- Integrated into responsibilities
  - Administrator, DNS, MD, Board
- Adequate resources
  - Designate who is lead
  - Facility-wide training
  - Ensure staff time
  - Set expectations

QAPI Awareness Campaign

- Formal plan
- Communicate with stakeholders
- Asking for quality concerns
- Process to get feedback
  - How easy do you make it for staff and customers to tell you about what's frustrating them?


Safety Team
Clinical Care Team
Marketing and Community Relations Team
Quality of Life Team
Employee Engagement Team
QAPI Steering Committee

Commitment

To reduce re-hospitalizations –

- Resources – education and equipment
- Review each unplanned re-hospitalization
  - Determine - Avoidable or Unavoidable?
- Identify opportunities for improvement
  - Identify patterns and ER bounce-backs
  - Minimize organizational barriers
  - Monitor structural and process measures

Feedback, Data Systems and Monitoring

Measurement Components

- Structural measures –
  - the *capacity* to prevent avoidable re-hospitalizations
- Process measures –
  - *performance* necessary to prevent avoidable re-hospitalizations
- Outcome measure – Re-Hospitalization Rate

Structural Measures

- Staffing ratios
  - Total nursing hours per day – 3.95
  - Total RN hours per day - .90
- # of vacant positions = 0
- # of shifts worked by agency staff = 0
- # of shifts understaffed = 0

Structural Measures

- Staff turnover
  - Total departures/average number of staff = 30%
- Staff retention
  - Staff with one year of service/avg. number of staff = 85%

Structural Measure

- Staff Satisfaction
  - Overall satisfaction = 90% “Excellent/Good”
  - Recommendation to others = 90% “Excellent/ Good”

Process Measures

- The% of new admissions with risk assessments complete and care plan initiated within the first 12 hours = 100%
- Presence of physicians or NPs = 10 hrs. per week
- Consistent Assignment = 95%

Process Measures

- Employee absenteeism = less than 30 call-outs per month per 100 FT staff
- Call light response time = 3 minutes
- The % of new admissions seen by their attending physician in the first 12 hours = 90%

Process Measures

- The % of new admissions readmissions with an updated POLST form in the chart within 24 hours = 80%

- The % of new admissions or readmissions who meet with the social worker and confirm the POLST within 3 days = 90%

QAPI Data Dashboard

Performance Improvement Projects


Safety Team
Clinical Care Team
Marketing and Community Relations Team
Quality of Life Team
Employee Engagement Team
QAPI Steering Committee

Identify and Prioritize Your Quality Problems

- Structural measures
- Process measures
- Outcomes
- Observations
- Feedback/comments

Survey Deficiency Score: Weights for Different Types of Deficiencies

Severity	Scope		
	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J 50 points (75 points)	K 100 points (125 points)	L 150 points (175 points)
Actual harm that is not immediate jeopardy	G 20 points	H 35 points (40 points)	I 45 points (50 points)
No actual harm with potential for more than min. harm that is not IJ	D 4 points	E 8 points	F 16 points (20 points)
No actual harm with potential for min. harm	A 0 point	B 0 points	C 0 points

Systematic Analysis and Systematic Action

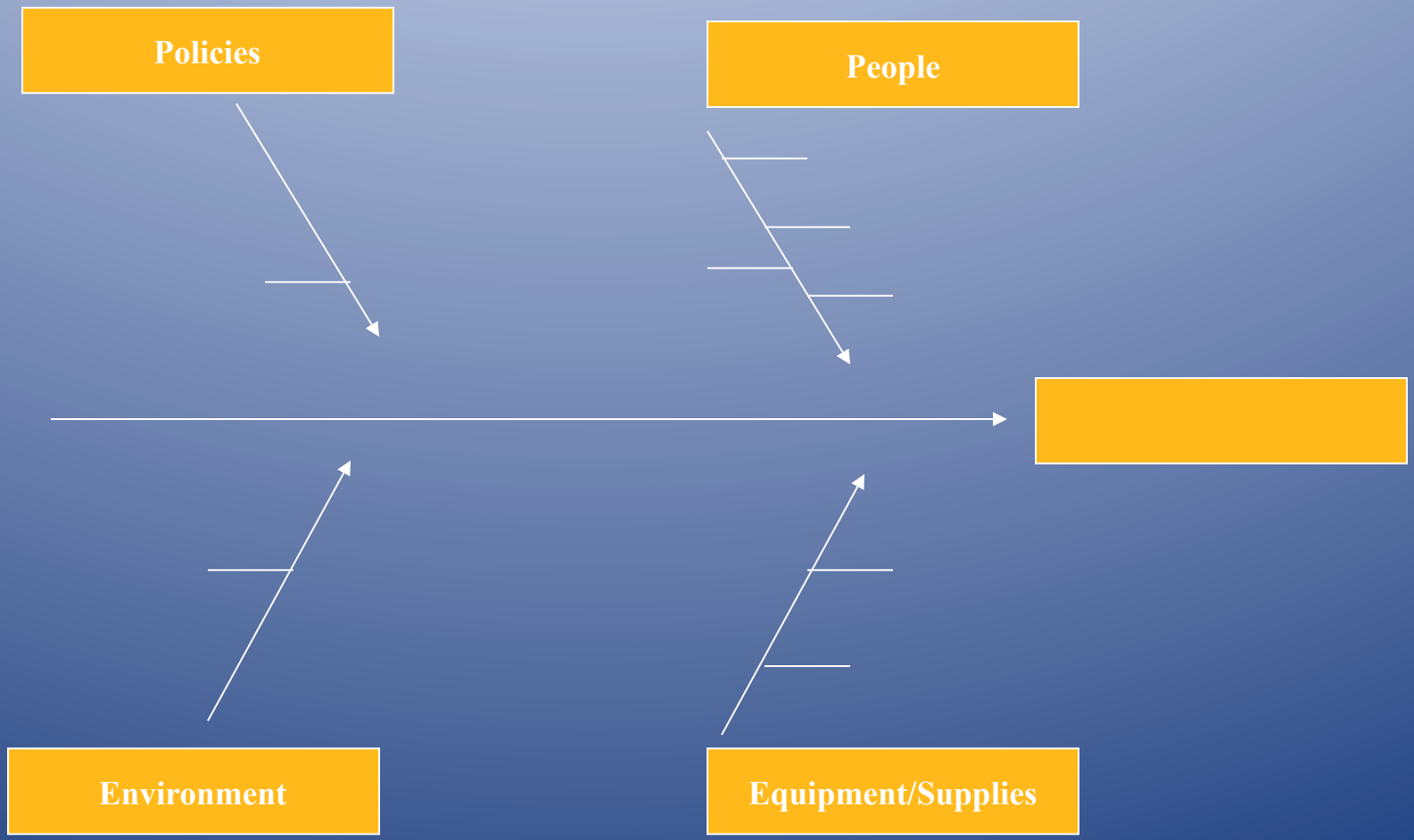
Creating Climate Where the Truth is Heard

Four key practices:

- From data to knowledge to action
- Conduct autopsies without blame
- Engage in dialogue, not coercion
- Lead with questions
  - Root-Cause Analysis

Collins, J. 2001

Cause and Effect Diagram



Root Cause Analysis

QAPI Leadership Paradigm

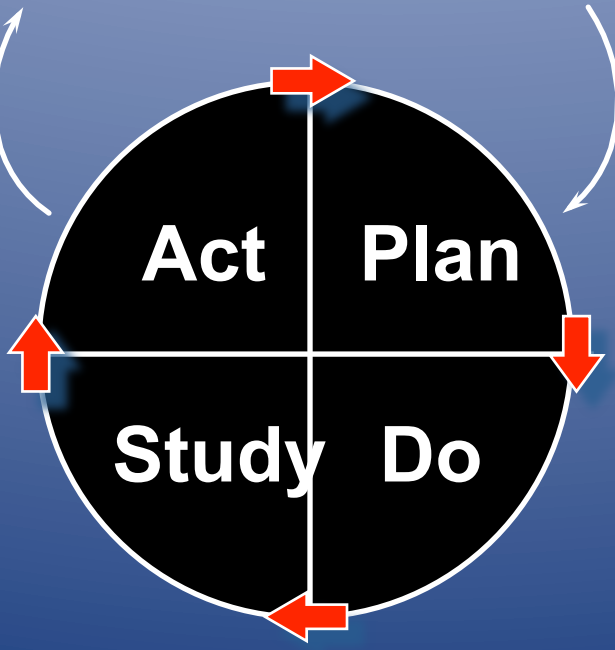
- Causes are many
  - Solutions multi-faceted
- Root cause analysis - a path to knowledge
- Stakeholders involved
- Need cooperation

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?



QAPI

A checklist for effective leadership -

- Enhances my competence
- Reminds me to listen
- Triggers me to include stakeholders
- Keeps me humble
- Improves my outcomes

National QAPI Rollout Plans

- Release of toolkits
- Outreach to national and state stakeholders
- Continued identification of resources
- Continued enhancements to web library
- Finalize the regulation

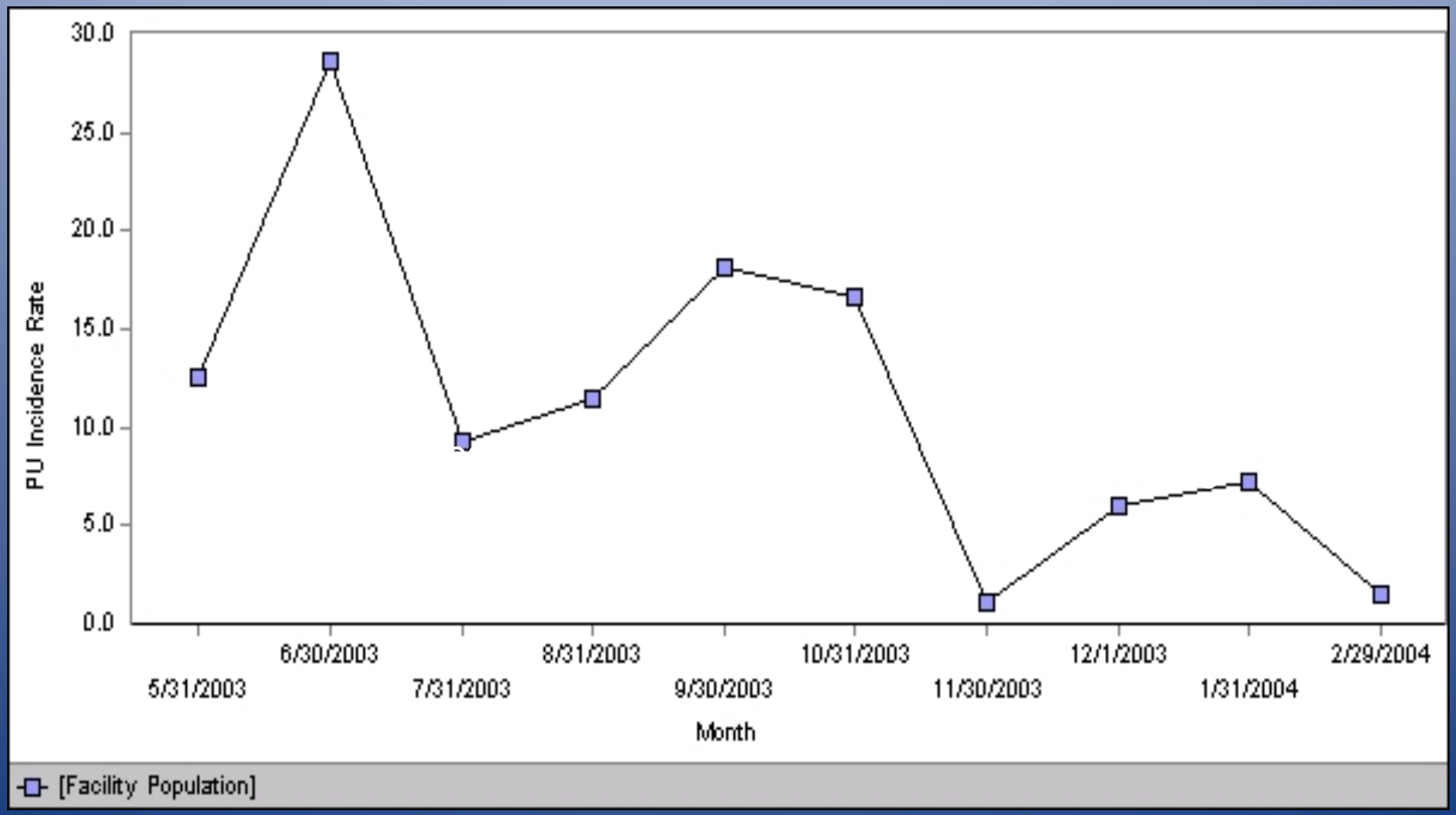
QAPI – Wound Care

David Farrell, LNHA, MSW
Senior Director
The Green House Project

Disclosure Statement

- I have no relevant financial relationships with a commercial interest to disclose.

Pressure Ulcers - Incidence



Measurement Triggers Action

- QAPI Questions -
- What are we going to change?
- How will we know if it works?
- When will it start?
- How can I assist?
- When will we get people involved?
- How will we keep people informed?

Contact Information

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Wound Diagnosis and Management - Workshop

Deb Bakerjian PhD, RN, FNP, FAANP
Senior Director for NPPA Clinical Education & Practice
Assistant Adjunct Professor
Betty Irene Moore School of Nursing
University of CA, Davis

Disclosures

- National Advisory Board for Omnicare Pharmacy
- Member National Quality Forum – Common Formats

- I have no financial disclosures relevant to this presentation

Learning Objectives

- Identify 3 clinical and 3 non-clinical factors that contribute to wound care quality
- Explain the root cause analysis process
- Demonstrate knowledge of risk factors
- Recall the basic prevention processes
- Recognize specific wound types and stages and match with an appropriate treatment approach

Wound Diagnosis & Management

CALTCM- May 2,2014

Deb Bakerjian PhD, RN, FNP, FAANP
Senior Director for NPPA Clinical Education & Practice
Assistant Adjunct Professor
Betty Irene Moore School of Nursing
University of CA, Davis

UCDAVIS
BETTY IRENE MOORE SCHOOL OF NURSING

Disclosures

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- I have no financial disclosures relevant to this presentation

Objectives

- Recognize 6 stages of pressure ulcers
- Differentiate basic treatments between various pressure ulcers
- Recall features of MDS 3.0
- Become familiar with new evidence related to pressure ulcer care

SOME PICTURES OF WOUNDS WITH PERMISSION FROM :

Barbara Bates-Jensen, PhD, RN, CWOCN
Associate Professor, UCLA School of Nursing and David Geffen School of Medicine, Division of Geriatrics
Research Nurse, The Veterans Administration Greater Los Angeles Healthcare System

KEY ACTIONS FOR PRESSURE ULCER IMPROVEMENT

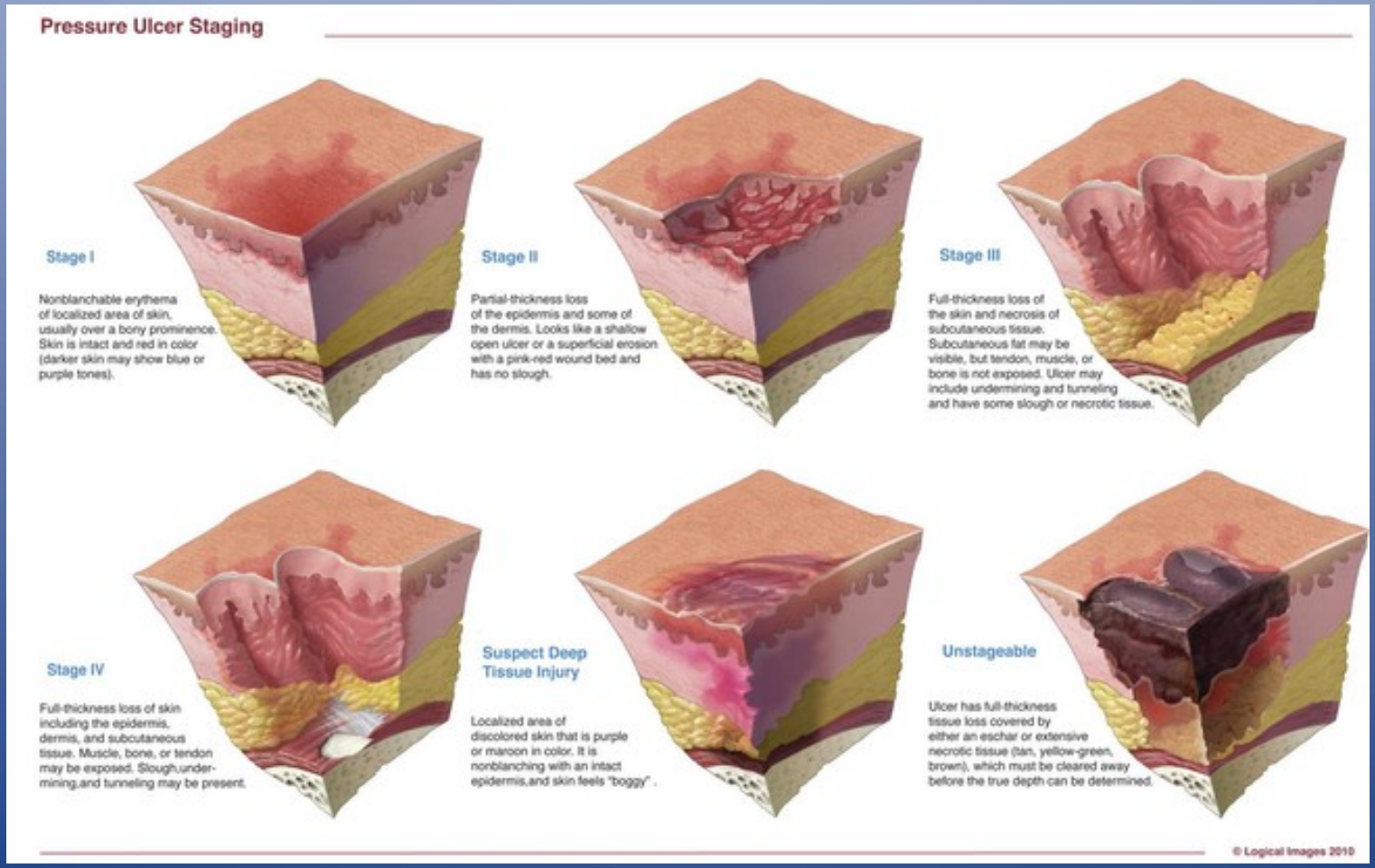
1. Update staging definitions & ensure accurate diagnosis- WHY did the ulcer form?
2. Standardize risk & wound assessment
3. Conduct standardized risk assessment on admission
   a) Within 24 hrs
   b) Within 8 hrs preferable
4. Institute PU prevention program that includes:
   a) Pressure redistribution support surface use
   b) Systematic scheduled repositioning
   c) Daily skin inspection
   d) Incontinence care
5. Nutrition assessment for ‘at risk’ patients
6. Institute multi-disciplinary wound team

AUDIENCE PARTICIPATION #1

1. How many pressure ulcer Stages are there?
    a) 4
    b) 5
    c) 6
    d) None of the above

Correct Answer is c) – 6
NPUAP Pressure Ulcer Stages/Categories. The National Pressure Ulcer Advisory Panel redefined the definition of a pressure ulcer and the stages of pressure ulcers in 2007, including the original **4 stages** and adding **2 stages** on deep tissue injury and unstageable pressure ulcers.

Pressure Ulcer Stages



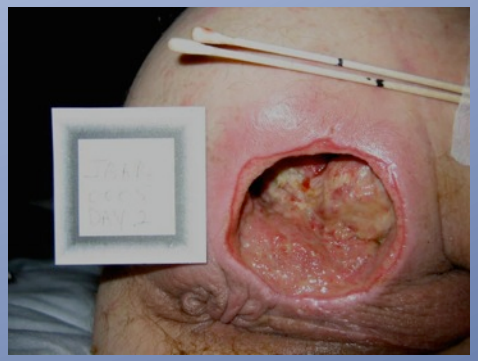
Audience Response #2

Match to the correct Stage

1. Stage 1
2. Stage 2
3. Stage 3
4. Stage 4
5. Unstageable
6. Deep Tissue Injury

a) #4 - Stage 4
b) #3 - Stage 3
c) #5 - Unstageable

a)



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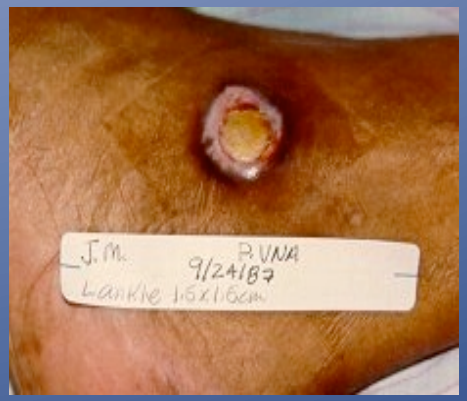

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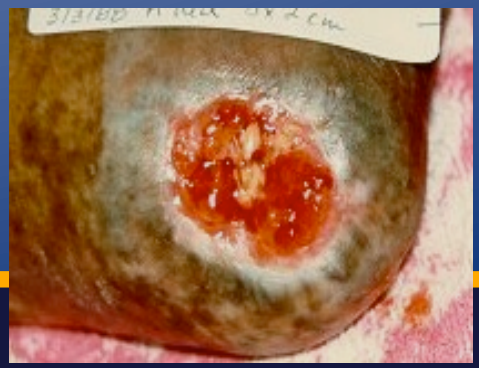
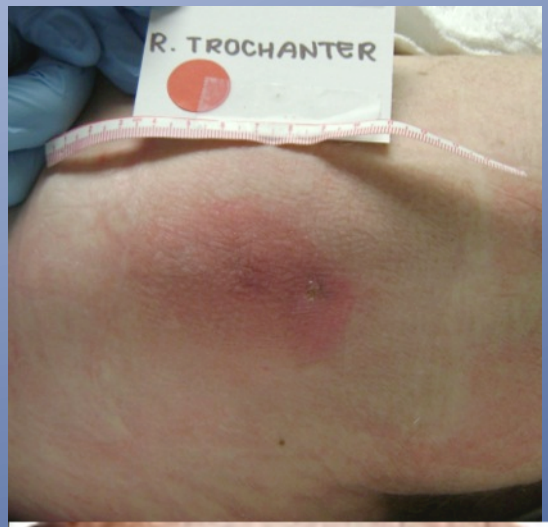
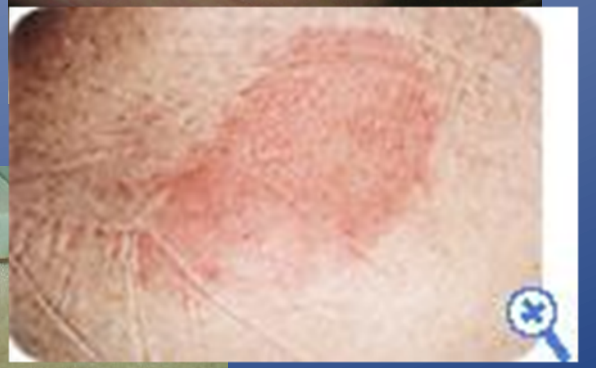
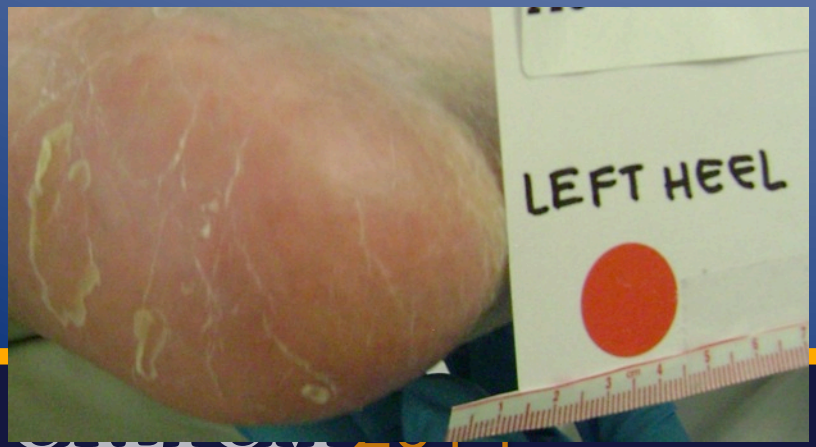


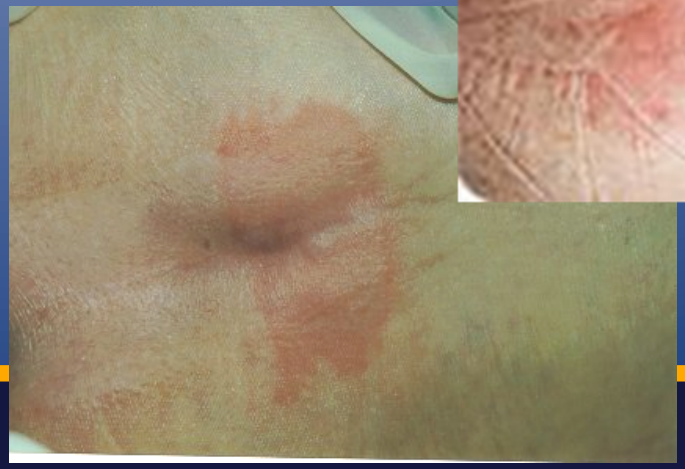
Stage 1

- Intact skin, non-blanchable redness of a localized area; usually over bony prominence
- May indicate “at risk” persons
- Area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue



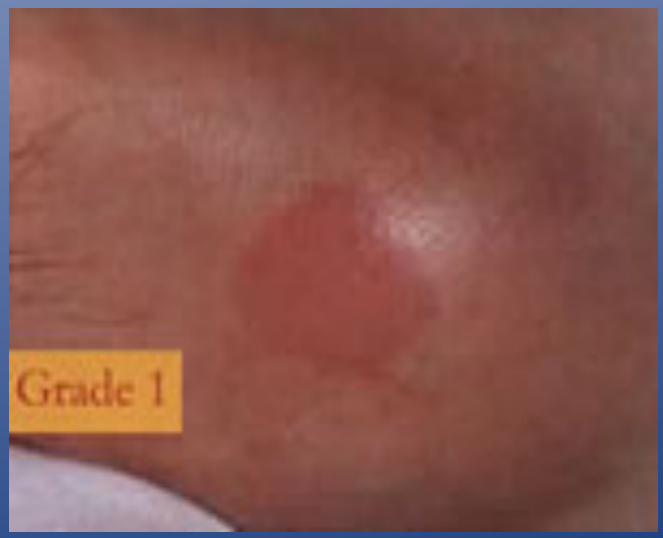






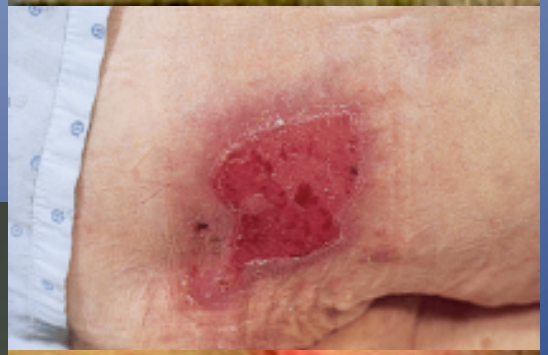
Stage 1

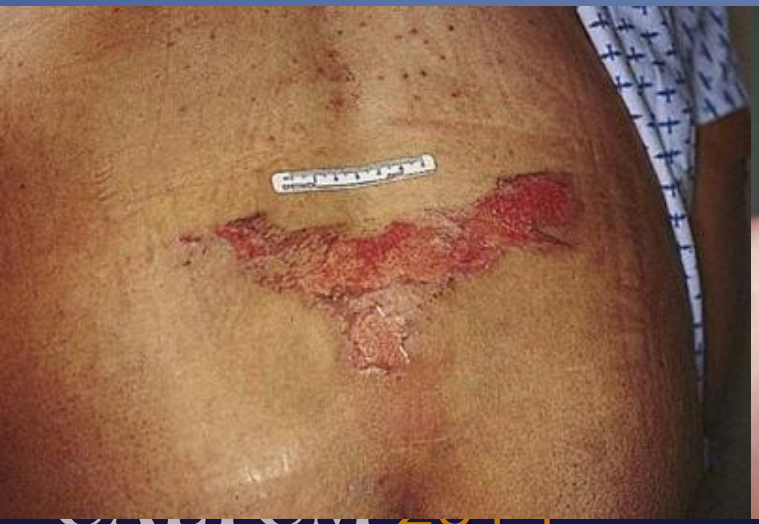
- Stage I may be difficult to detect in individuals with dark skin tones.
- Darkly pigmented skin may not have visible blanching; color may differ from surrounding area

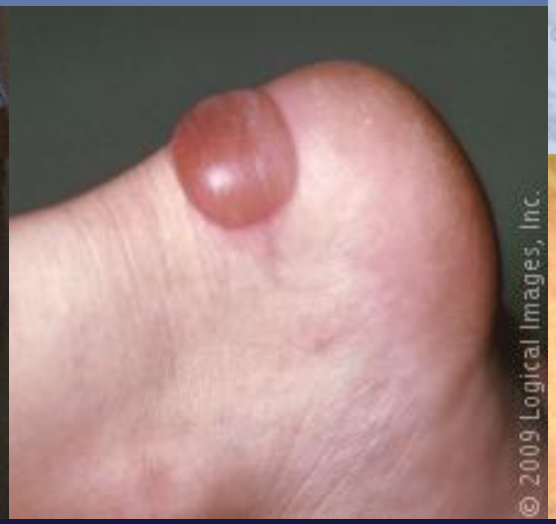


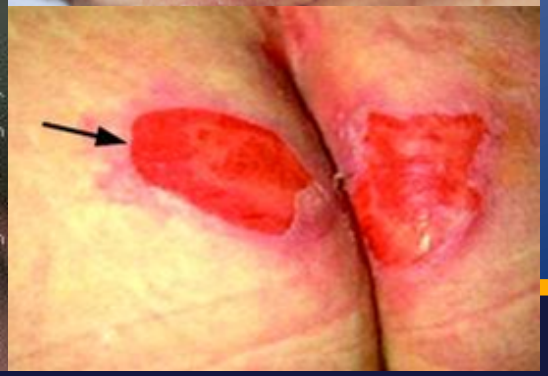
Stage 2

- Partial thickness loss of dermis
- Presents as shallow open ulcer with a red pink wound bed, without slough
- May also present as an intact or open/ ruptured serum-filled blister
- Presents as a shiny or dry shallow ulcer without slough or bruising.*





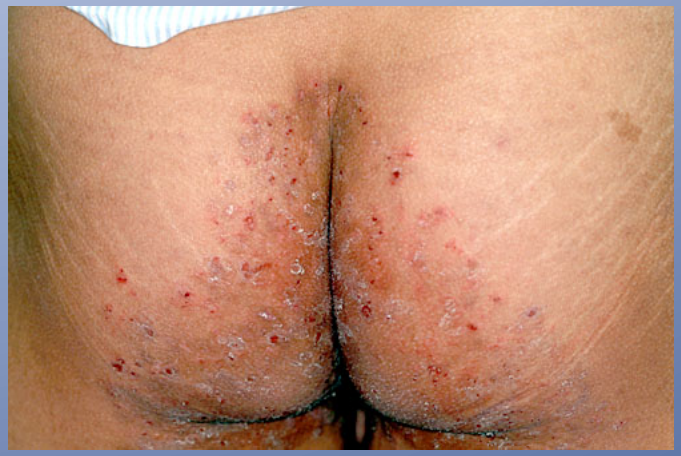


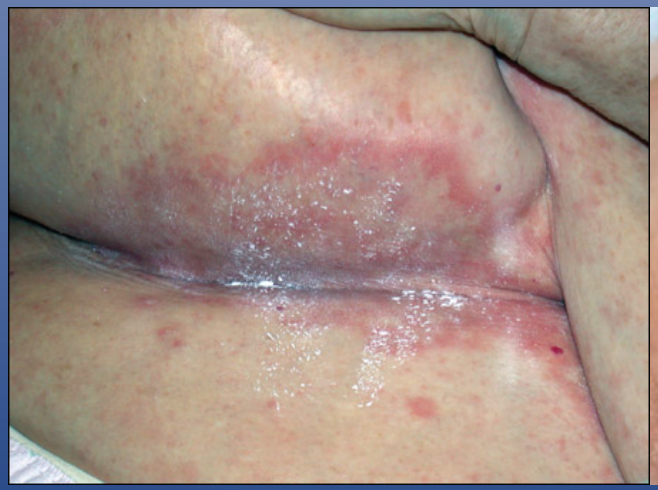


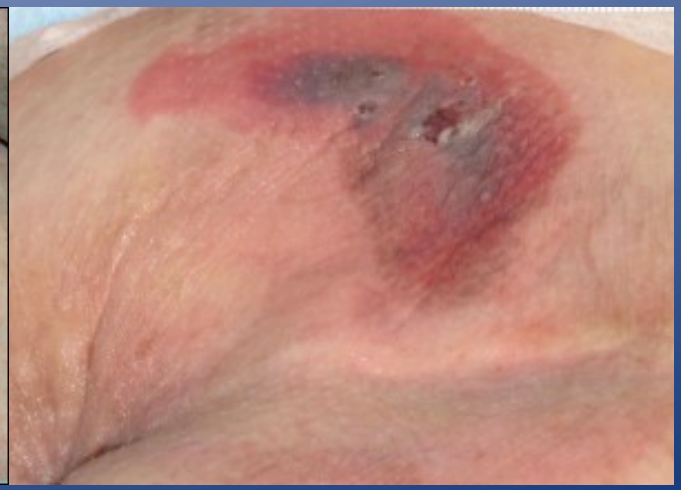
NOT Stage 2

- DO NOT use to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation
- Presents as a shiny or dry shallow ulcer without slough or bruising*

*Bruising indicates suspected deep tissue injury

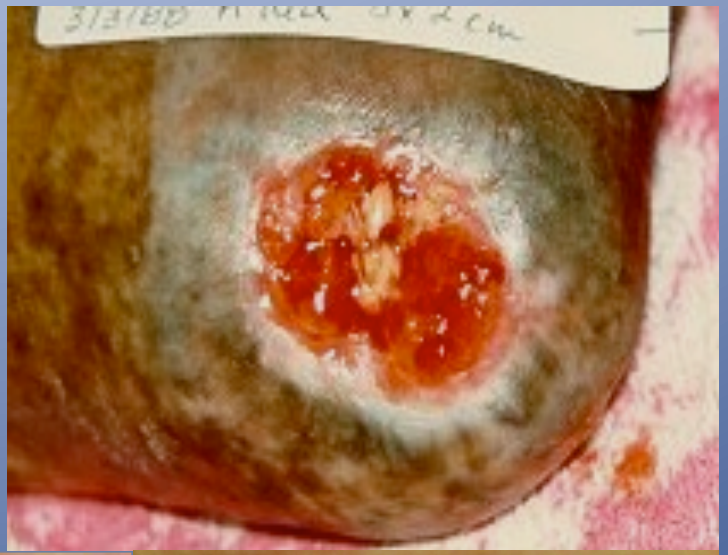


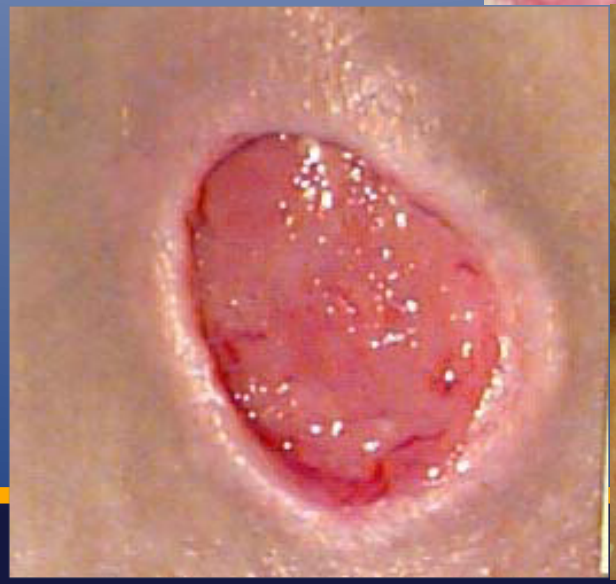


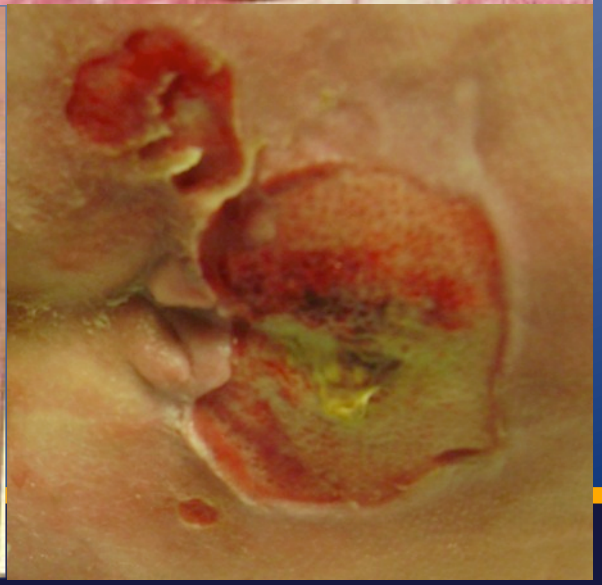


Stage 3

- Full thickness tissue loss
- Subcutaneous fat may be visible but bone, tendon or muscle are not exposed
- Slough may be present but does not obscure the depth of tissue loss
- May include undermining and tunneling

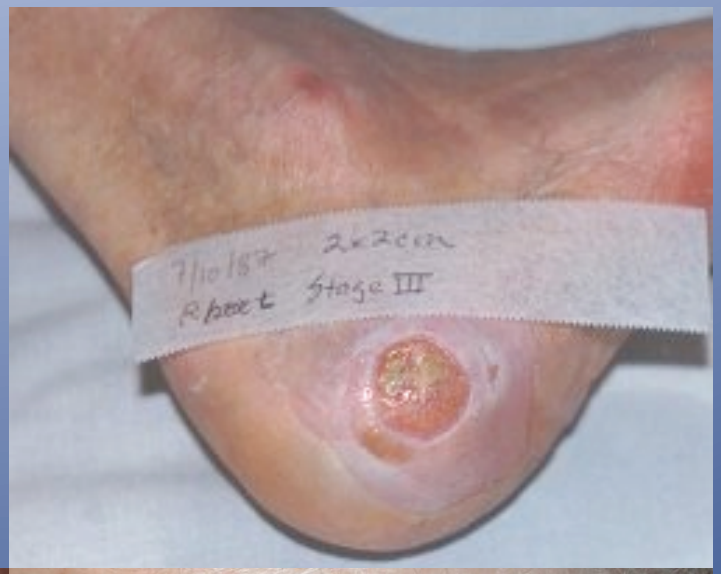


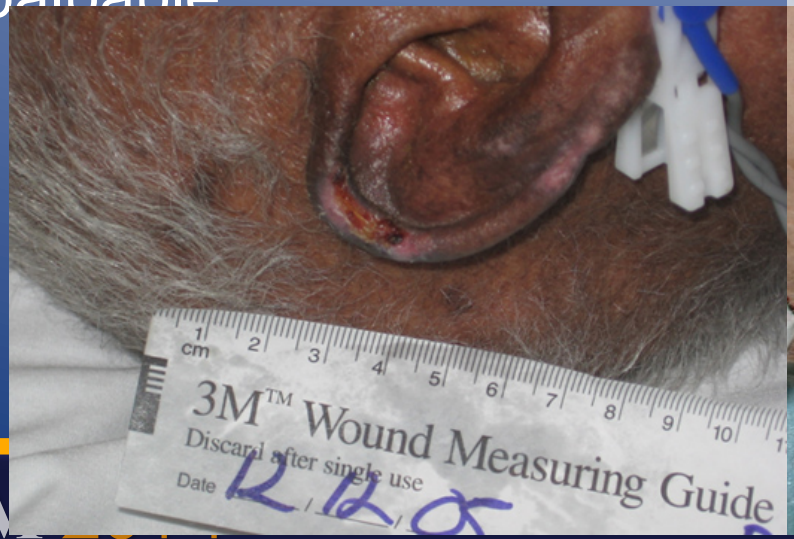


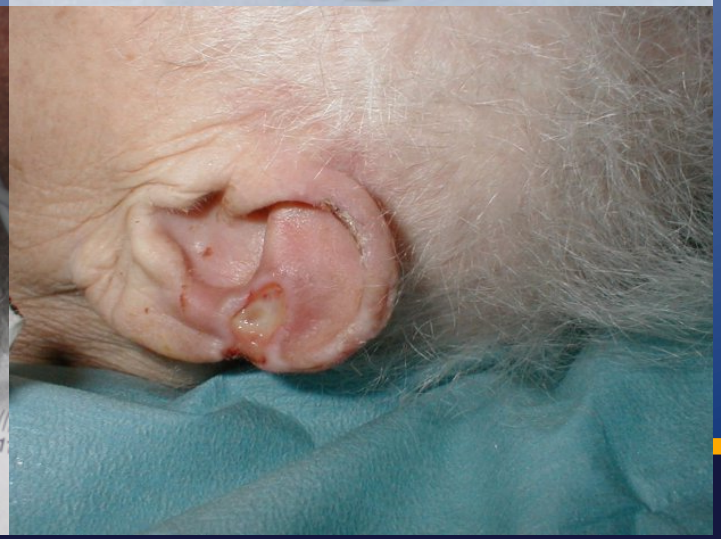


Stage 3

- The depth of a stage 3 pressure ulcer varies by anatomical location
- Bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Stage III ulcers can be shallow
- Bone or tendon not visible or directly palpable

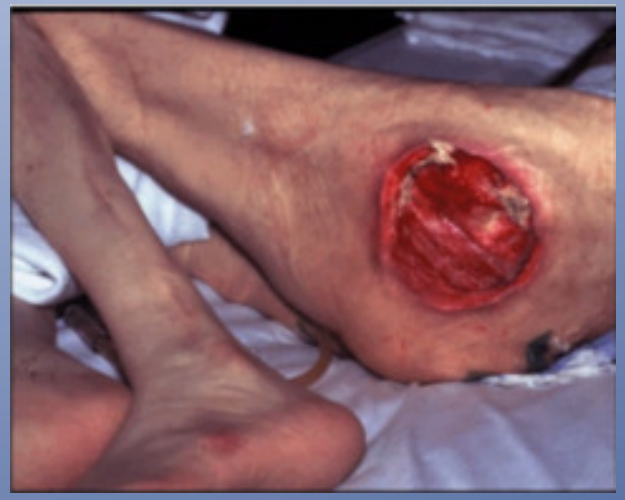


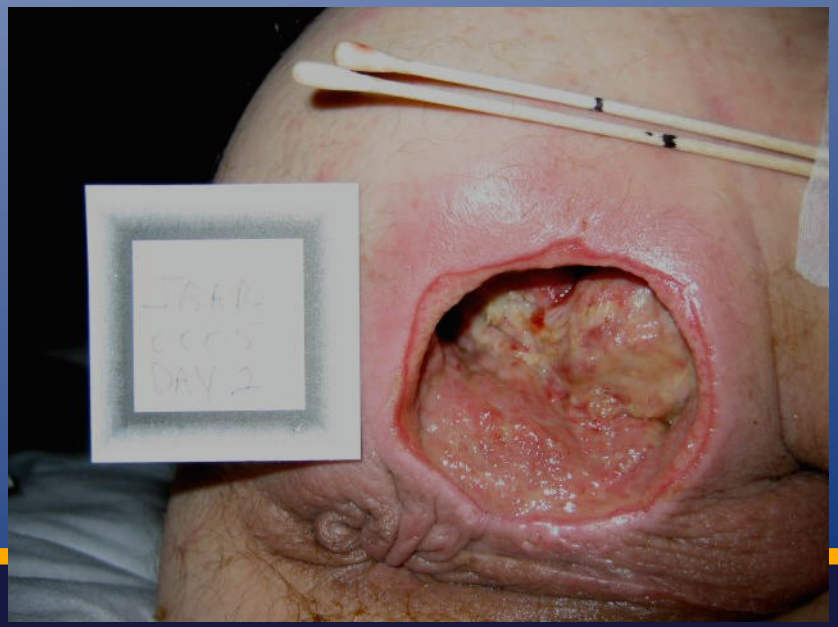




Stage 4

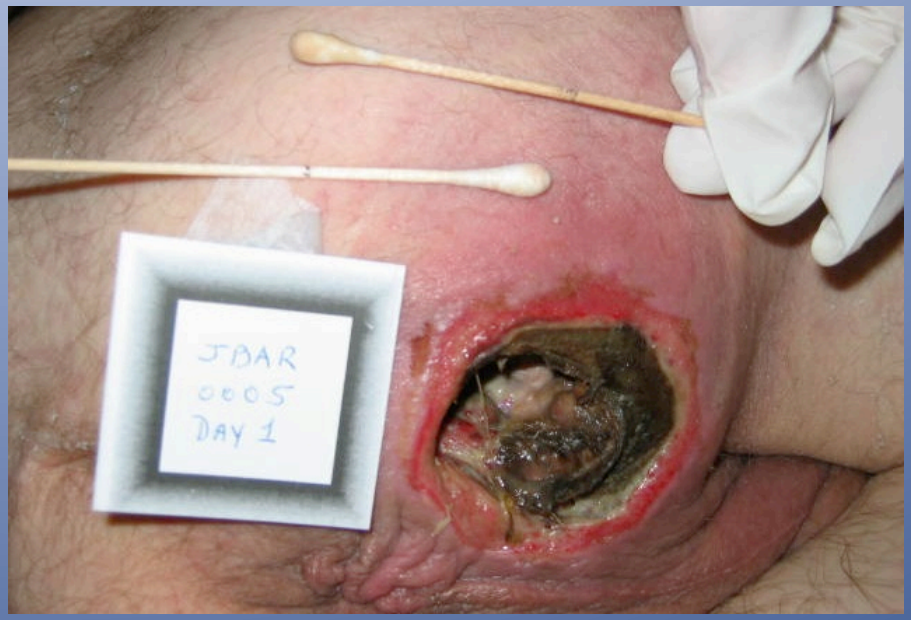
- Full thickness tissue loss with exposed bone, tendon or muscle
- Can extend into supporting structures, increasing risk for osteomyelitis
- Slough or eschar may be present on some parts of the wound bed
- Often include undermining and tunneling

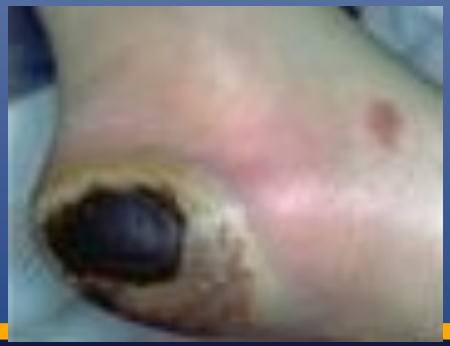


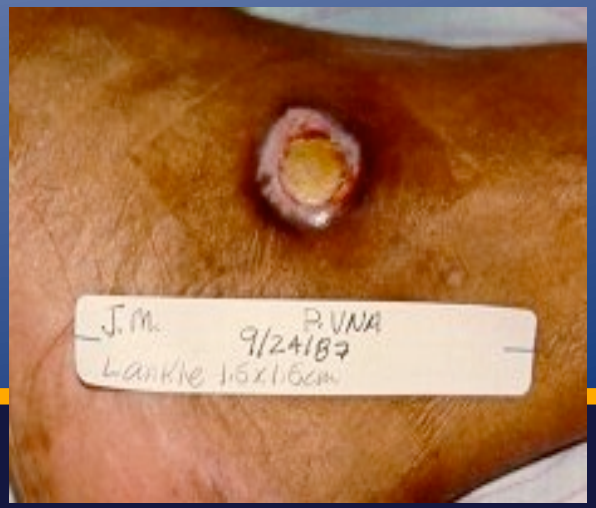


Unstageable

- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed
- Unable to visualize base

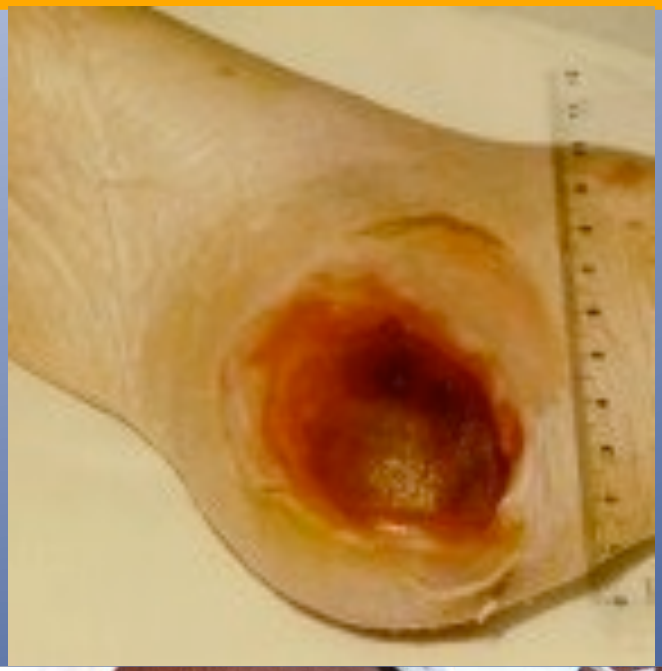


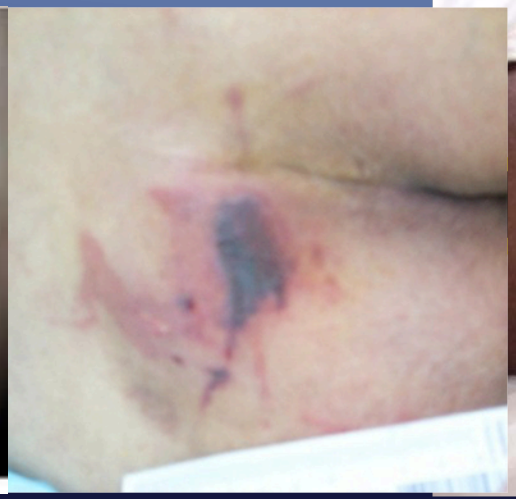


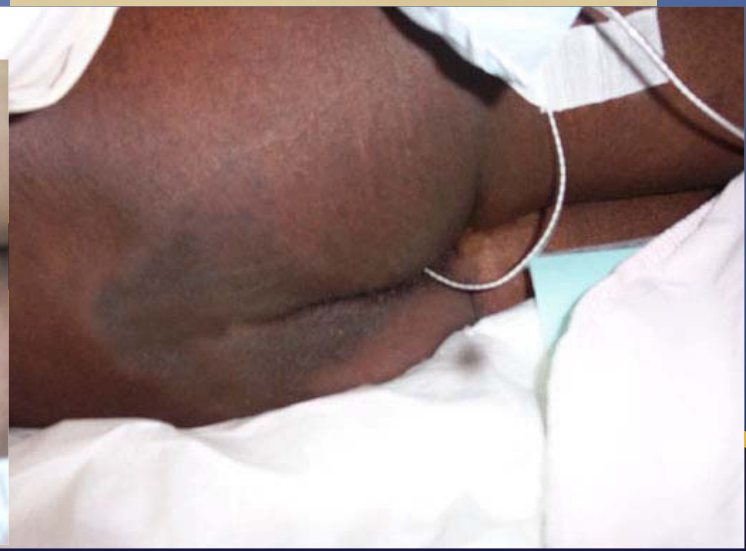


Suspected Deep Tissue Injury

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure &/or shear
- Area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler when compared to adjacent tissue







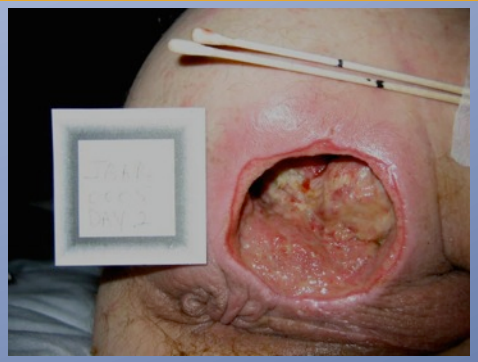
Audience Response #3

Match to the correct Stage

1. Stage 1
2. Stage 2
3. Stage 3
4. Stage 4
5. Unstageable
6. Deep Tissue Injury

a) #4 - Stage 4
b) #3 - Stage 3
c) #5 - Unstageable

a)



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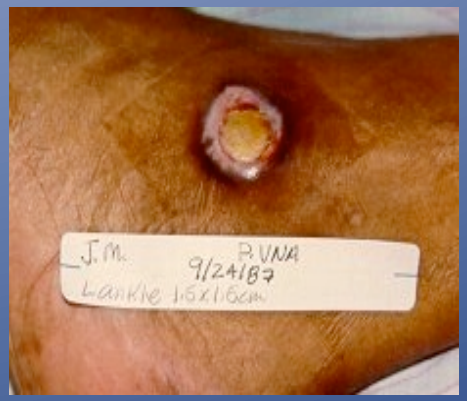
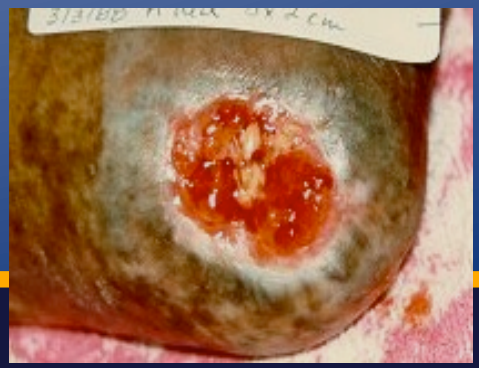
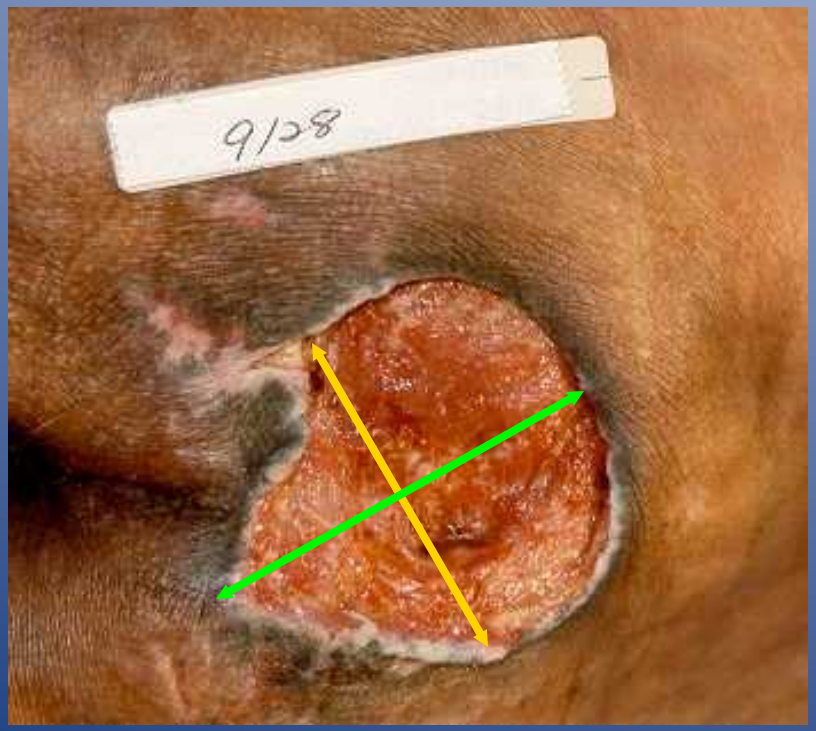


c)



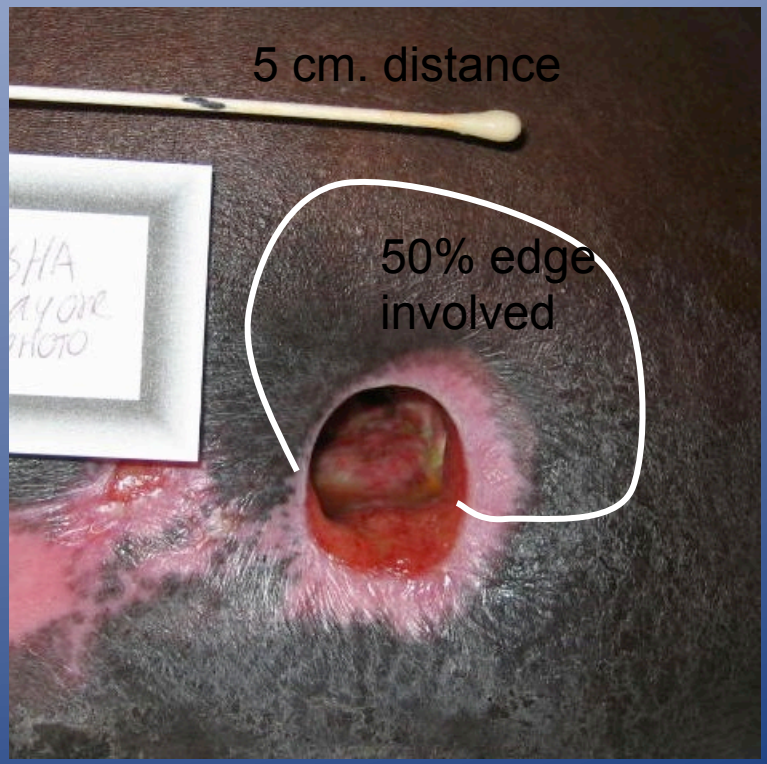
How To Evaluate Wound Size



- Measure weekly in centimeters
  - **Length** X Width
  - **Length = head to toe**
  - Width = left hip to right hip
  - ***Longest*** aspect of visible wound multiplied by perpendicular ***Widest*** aspect of visible wound
  - **Do the math** to get **surface area**; get a calculator if needed

Undermining

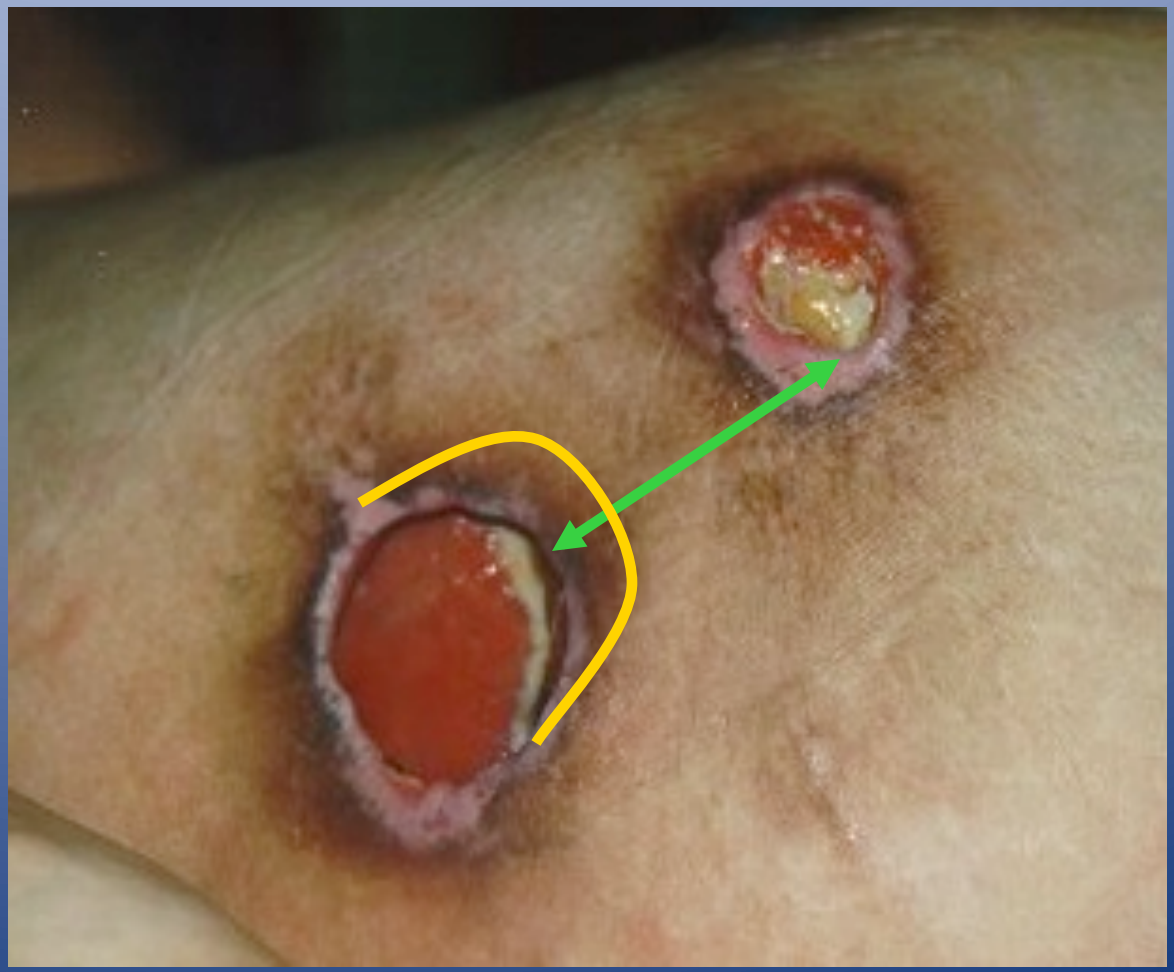
- Advance cotton-tipped applicator under wound edge until unable to gently probe further
- Measure distance from edge of wound to point where applicator can be palpated on skin surface
- Note percent of wound edge involved in undermining process



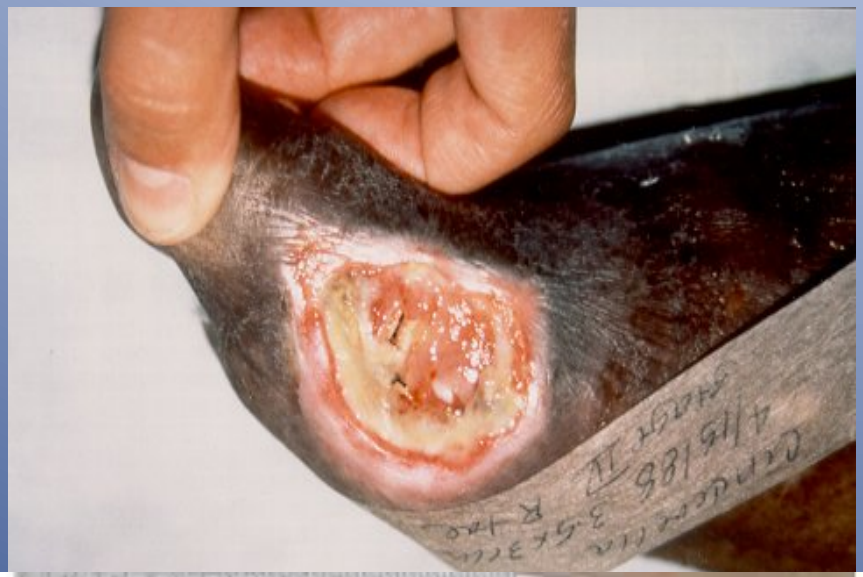
Undermining

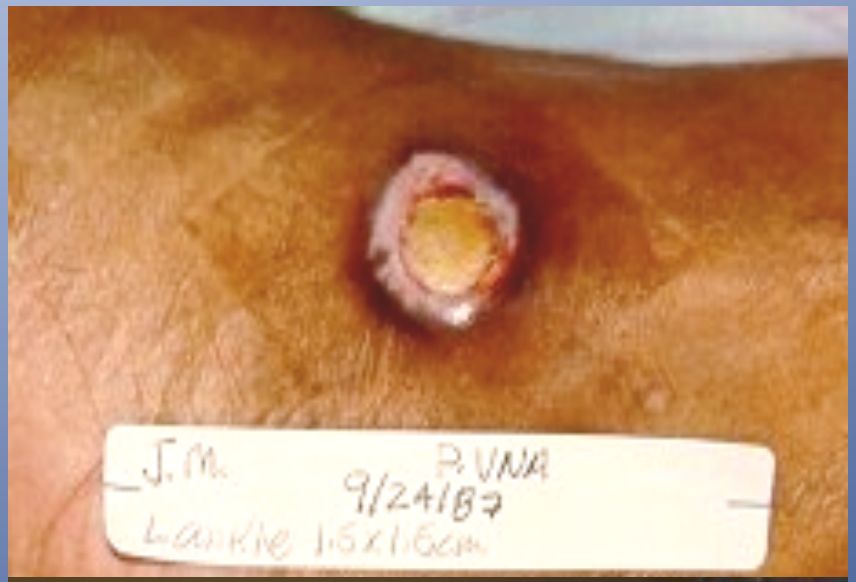
Undermined beyond 4 cm; the 2 ulcers are connected

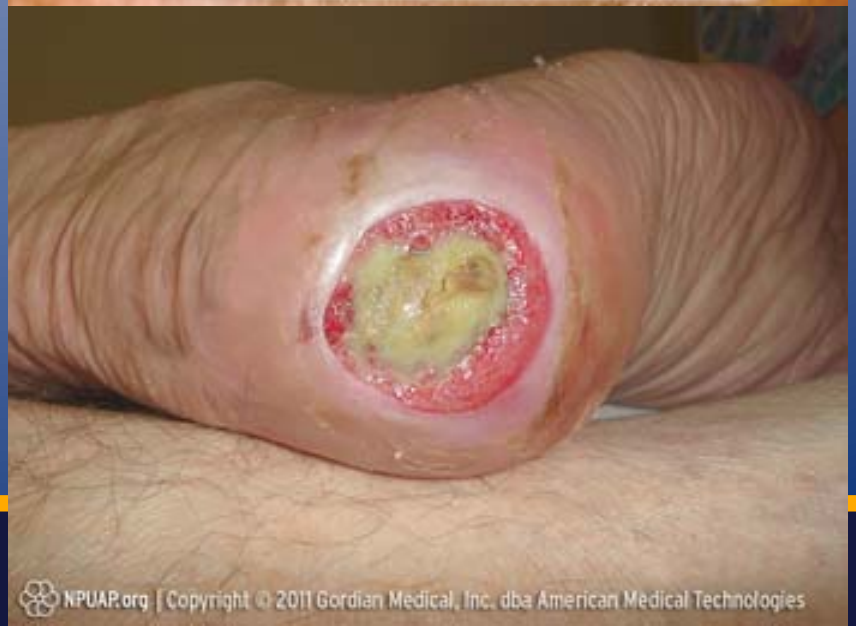
50% of wound edge involved in undermining process



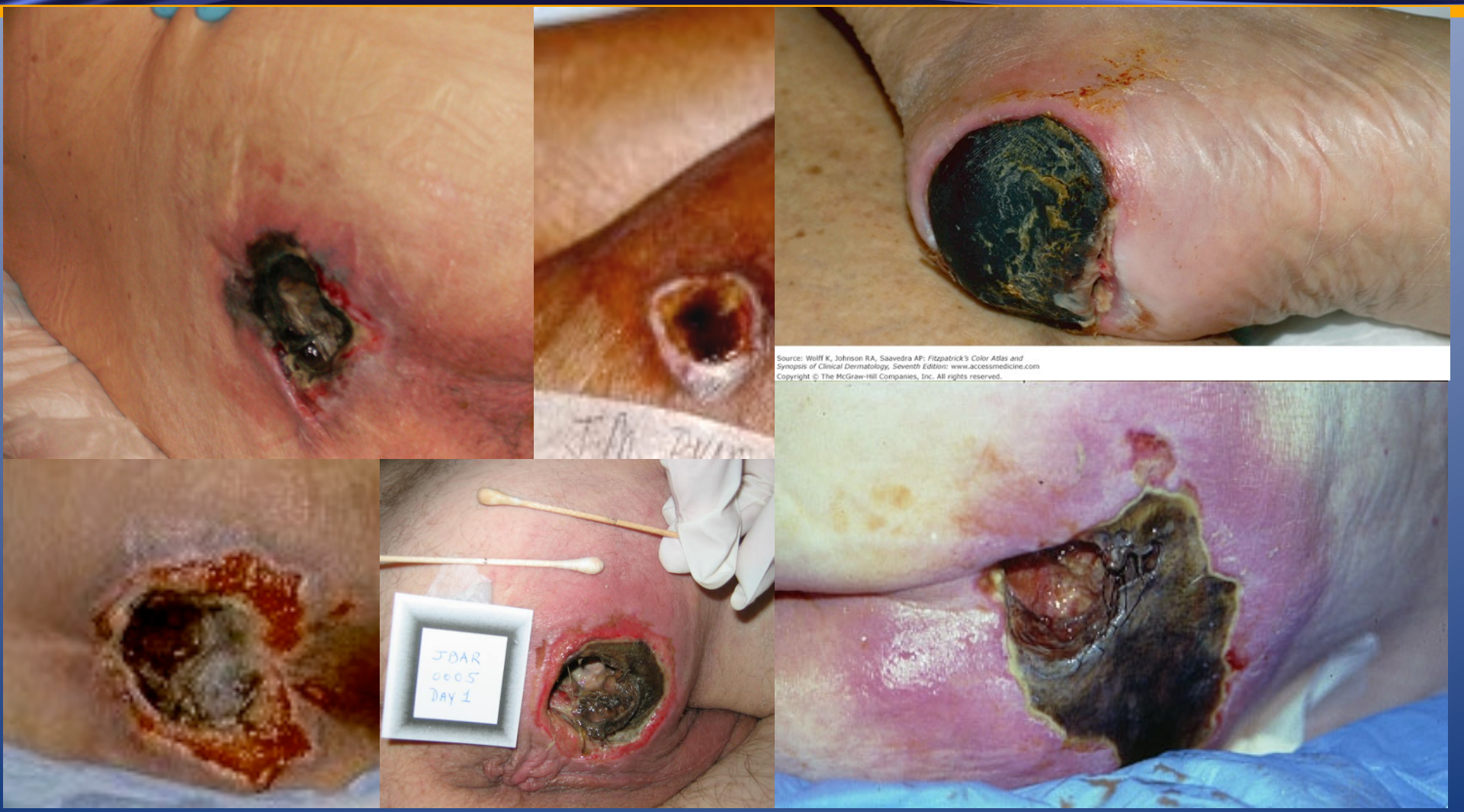
Necrotic Tissue: Slough



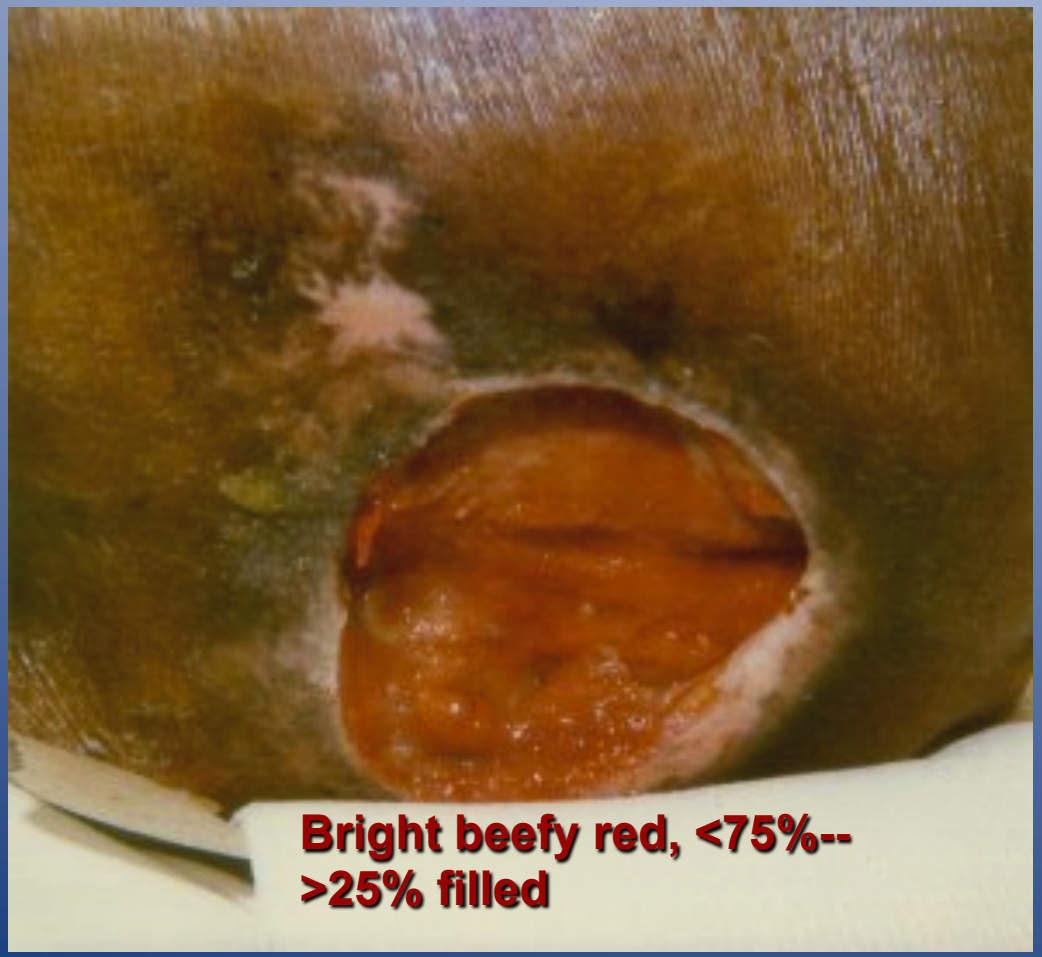




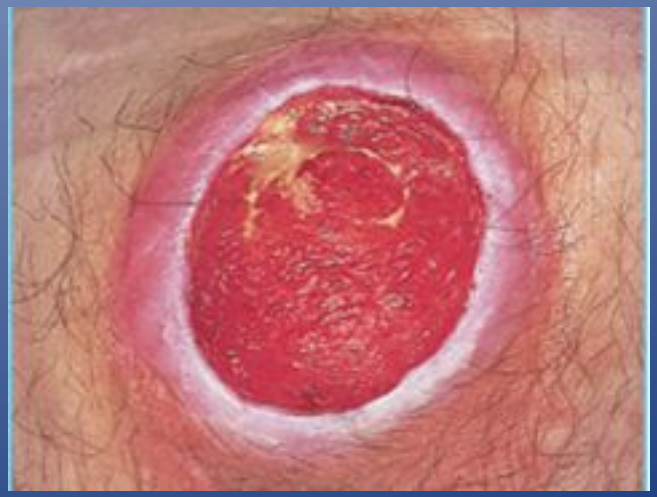
Necrotic Tissue: Eschar



Granulation Tissue

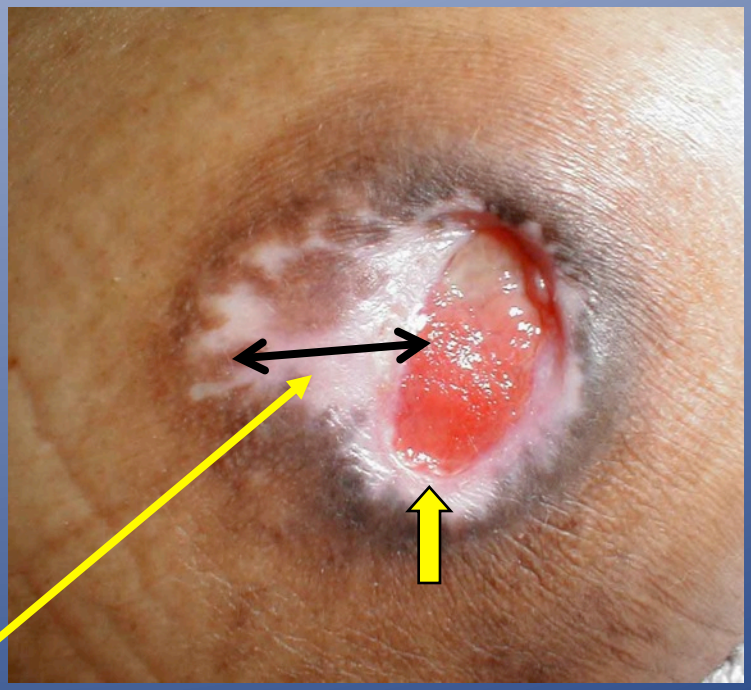


- Observe color
- Determine percent of wound filled with new growth



Epithelialization

- Observe for new growth at wound edge
- Measure extent of new growth into wound or judge how much of wound is re-surfaced with new skin
- **50% to <75% covered, epithelial tissue extends 0.5 cm into wound**



***Granulation: Bright beefy red >75% filled**

Audience Response #4

MDS 3.0 does NOT ask the following:

a) **Skin ulcer treatments**
b) **Staging of pressure ulcers**
c) **Moisture associated skin damage (MASD)**
d) **Undermining and tunneling**
e) **None of the above**

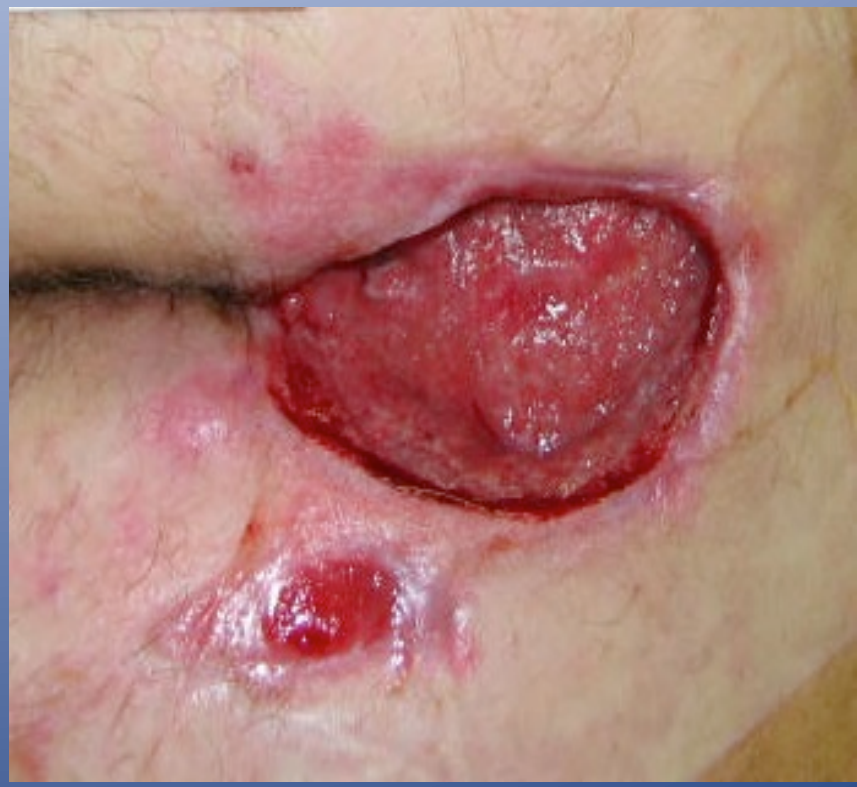
Correct Answer is d) – MDS 3.0 does not ask whether ulcers have undermining or tunneling

MDS 3.0 Section M

- Determine risk
- Unhealed pressure ulcers- Stage 1 or higher
- Current number of unhealed
  - Stage 1-4 pressure ulcers
  - Unstageable non-removeable dressing/device, slough/eschar
  - Unstageable DTI
- Dimensions of unhealed – Stage 3 or 4 or Eschar
- Most severe type
- Worsening pressure ulcer since last assessment or last admission
- Healed pressure ulcers Stage 1-4
- Number venous and arterial ulcers
- Other ulcers, wounds, skin problems – diabetic foot ulcers
- Skin and ulcer treatments

Status of Ulcer

- Worsening ulcers
  - Number of each stage that worsened (Stage advanced; e.g., stage 2 to 3)
- Healing ulcers
  - Number at each stage healed
  - Re-epithelialized or resurfaced with new skin, since last MDS assessment



Risk Assessment - Braden Scale

- **Score range 6-23**
- **Low score = High risk**
  - 18 or below indicates risk
  - 10 or below indicates HIGH risk
- *BUT choose the cut score that works for your setting & population*
- *USE the same tool for Acute care, LTC, home care & **communicate** findings during transitions*
- *Assess on admission (within 24 hrs, 8 hrs preferably) and weekly for 4 weeks, then quarterly*

If At Risk…

Consistently implement a prevention plan:

1. Daily skin inspection
2. Pressure redistribution chair & bed
3. Repositioning only for those who can’t move
4. Nutrition assessment
5. Incontinence care

Level of Evidence: Prevention Programs

- Regular skin inspection and assessment
- Improved mobility
- Adequate nutritional intake
- Documentation of the skin examination
- General educational interventions for hospital staff
  - All supported by before-after study designs
- Use of pressure reduction support surfaces
  - Supported by RCTs and clinical trials
- Historical recommendation turn q 2h
  - Previously no well-designed controlled trials that examine its effect in the absence of other interventions.
  - TURN Study – Preliminary results

Pressure Redistribution

- Support Surfaces as standard equipment
  - Redistributes pressure
  - Relative reduction of pressure ulcers by 60% compared to standard hospital mattresses
- Wheelchair support surfaces; lower pressure ulcer incidence
  - Harder to implement support surfaces on chairs
  - Easy to audit process
- Check equipment: how old are your surfaces?
- What type of surfaces?
- Are you using them appropriately?

Preventing Pressure Ulcers: A Multisite Randomized Controlled Trial in Nursing Homes

Nancy Bergstrom, PhD, RN, FAAN,[1] Susan D. Horn, PhD,[2] Mary Rapp, PhD, RN,[1] Anita Stern, PhD, RN,[3] Ryan Barrett, BSc,[2] Michael Watkiss, BFA,[2] Murray Krahn, MD, MSc, FRCPC[3]

1. University of Texas Health Sciences Center at Houston, Houston, Texas, USA.
2. International Severity Information Systems, Inc. and the Institute for Clinical Outcomes, Salt Lake City, Utah, USA.
3. Toronto Health Economics and Technology Assessment Collaborative, Toronto, Ontario, Canada.

Presented to the Ontario Health Technology Advisory Committee on April 26, 2013.
Final report

The PROBLEM

- The most basic strategy recommended to prevent pressure ulcers is turning or repositioning residents at 2-hr intervals
- Turning q2 hrs X12 times daily X 365 days = 4,380 turning episodes per patient yearly
- Estimating 5 min/turn, 21,900 minutes, 365 hours, or 9.125 weeks of staff time per resident annually
- Turning often requires 2 staff members, doubling the cost of the intervention

TURN STUDY

- RCT study to examine pressure at interface of bony prominences and support surfaces
- Goal – what is the optimum frequency for repositioning in LTC?
- Participants had NO pressure ulcers at start, with moderate or high risk based on Braden score
- 20 U.S. and 7 Canadian NHs

Preliminary Findings

Sample	Number n=942	Percentage
Female	731	77.6
Caucasian	758	80.5
Cardiovascular	713	75.7
Dementia	672	71.3
Stage 1 or 2 w/o full thickness	1	.02%
Stage 2 w/o full thickness	19	2%
Full thickness development	0	

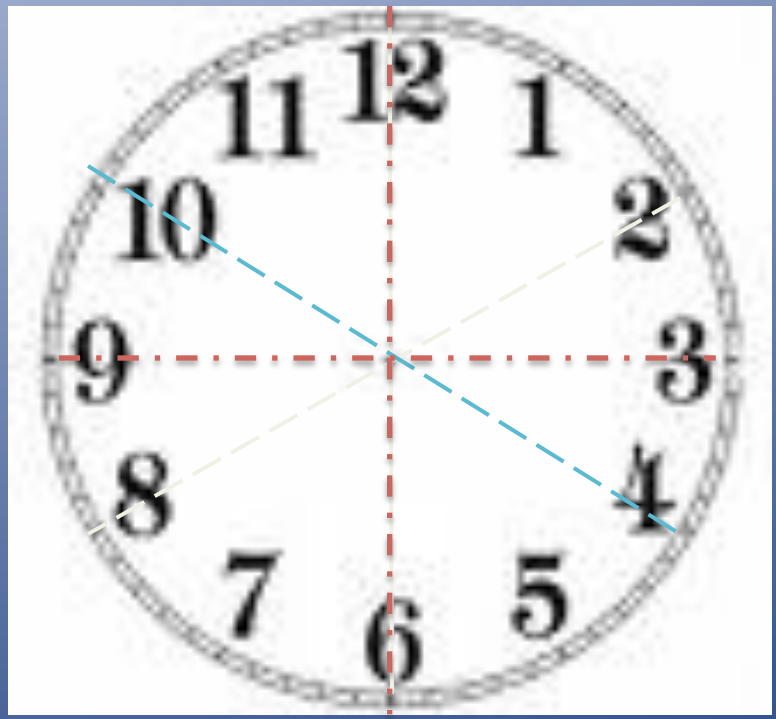
Turning Frequency	2 hrs	3 hrs	4 hrs	p value
Pressure Ulcer Incidence between turning hours	2.49%	.61%	3.05%	0.68

Preliminary Results from TURN Study
Draft Report – Ontario Health Technology

- Results support turning moderate & high-risk residents at intervals of 3- or 4- hours when they are on high-density foam replacement mattresses
- Turning at 3-hour and at 4-hour intervals is no worse than the current practice of turning every 2 hours
- Less frequent turning might increase sleep, improve quality of life, reduce staff injury, and save time for such other activities as feeding, walking, and toileting

How Do You Make Sure Turns & Repositioning Occur?

- Turning clocks
- Visual cues in room & medical record
- Auditory cues
- Grand turning rounds to audit process
- Monitor hand-offs – walking rounds
- CNAs are the primary preventionists



Nutrition Support

- 30-40 cal & 1-2 gms protein/kg/day if consistent with goals
- Adequate fluid intake
- Multi-vitamin supplement
- Tube feedings ***NO*** effect on ulcers
- ***NO*** evidence for additional supplementation of nutrients (Vitamins A,E,C, Arginine, Zinc)
- For those residents at risk:
  - ✓ Monitor nutrition by observing meal intake
  - ✓ Assist with meals as needed

Nutrition: What to implement?

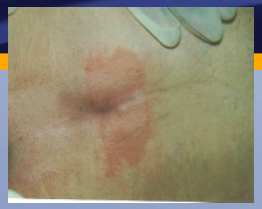
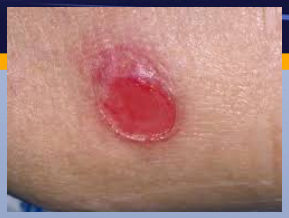
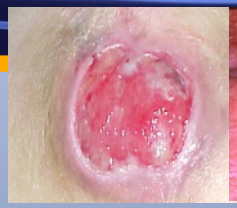
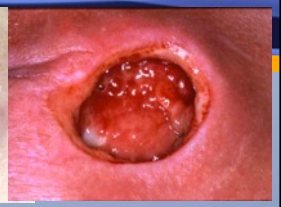
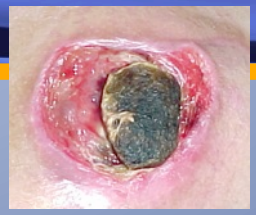
- Routine screen for nutrition status
  - ✓ Serum albumin ≥ 3.5mg/Dl
  - ✓ Nutrition screening assessment
  - ✓ Percent food & fluid consumed
- Dietician consult on admission
  - ✓ All determined ***at risk*** based on admission risk assessment
  - ✓ All with existing or history of pressure ulcer

Communication Essential to Success

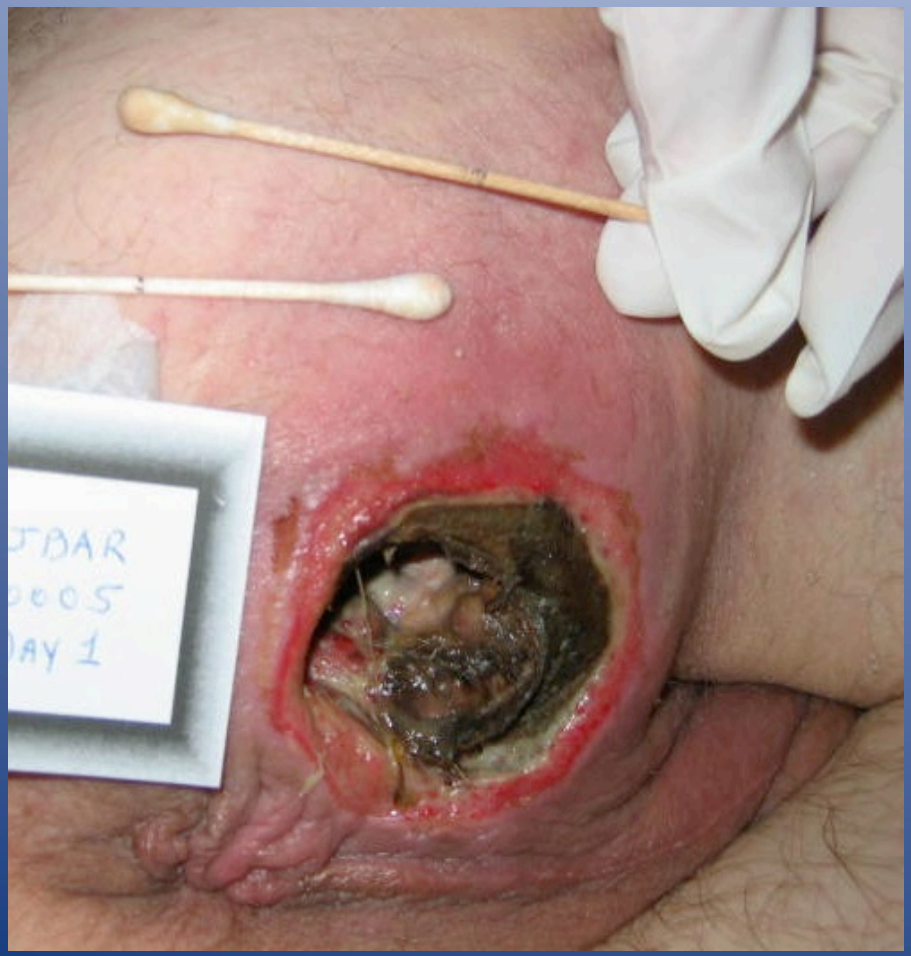
- Include key stakeholders:
  - ✓ Physician, nurse practitioner, physician assistant
  - ✓ Wound nurse specialist
  - ✓ Treatment nurse
  - ✓ Dietician
  - ✓ Physical therapy
  - ✓ Nurse aide
  - ✓ Supervisor
  - ✓ Administrator
- Weekly wound care rounds
- 5 minute feedback sessions weekly
- Hand-offs are key!

Treatment Considerations

- Treatments dependent on
  - ✓ Stage of wound
  - ✓ Moisture
  - ✓ Presence of slough or eschar
- Wound bed should be kept moist
- Surrounding skin should be kept dry

Wound Type	Stage I - Pressure Ulcer	Stage II - Pressure Ulcer or Partial Thickness Wound		Stage III or IV Pressure Ulcer or Full Thickness Wound		Wounds with Necrosis
				 		
Definitions	**Stage I -** An area where the epidermis is intact and the erythema (reddened skin) does not resolve within 30 minutes of pressure relief.	**Stage 2 -** An area of partial thickness loss of skin layers involving the epidermis and possibly penetrating into but not through the dermis		**Stage 3 -** Full thickness skin loss extending through the dermis to involve subcutaneous tissue	**Stage 4 -** Deep tissue destruction extending through subcutaneous tissue to fascia and may include muscle, tendon, joints, or bone	**Stage 4**– The base of the wound cannot be visualized – i.e. obscured by necrosis or yellow slough
Exudate	**PREVENTION**	**Dry to Light Exudate**	**Moderate Exudate**	**Dry to Light Exudate**	**Heavy Exudate**	**Wounds with Necrosis**
Dressings and Change Frequency	**Prevention Guidelines** Pressure relief to area Turn or reposition q2-4hr in bed with special mattress; q1hr in chair Pillow under calf to float heels, cushion needed if in WC/GC Monitor skin q 8 hours Protective Barrier if skin denuded, wet, & weepy Hydrocolloid Dresssing if friction involved	**Cleanse**: NS, H2O **If Dry:** apply Wound gel to hydrate **Cover:** Telfa type or Hydrocolloid Dressing **Change**: q3 days or when exudate reaches 1 inch from the edge	**Cleanse**: NS, H2O **Fill If Needed:** Calcium Alginate absorb exudate **Cover:** Gauze or hydrocolloid dressing **Change:** q3 days or when exudate reaches 1 inch from the edge	**Cleanse:** NS, H2O **If Dry:** apply Wound gel to hydrate **Fill If Needed:** Calcium alginate to absorb exudate **Cover:** Hydrocolloid dressing **Change:** q3 days or when exudate is 1 inch from edge	**Cleanse**: NS, H2O **Fill**: Calcium Alginate to absorb exudate or to fill dead space **Cover**: Gauze or hydrocolloid dressing **Change**: q3 days or when exudate is 1 inch from edge	**Cleanse:** NS, H2O **Necrotic Wounds:** To facilitate autolytic debridement – apply ¼ inch Wound-Gel on necrotic area covered by Hydrocolloid dressing OR Enzymatic can be used OR If gel & exudate create too much moisture use Calcium Alginate to absorb or Hydrocolloid Drsg alone to continue autolytic debridement **Change:** q3 days or when exudate reaches 1 inch from the edge

Ulcer Care: DEBRIDE



- Indicated if there is eschar or thick, dry slough
- Choice of debridement
  - Sharp (surgical)
  - mechanical, enzymatic, autolytic, or biosurgery
- A matter of preference
- Little evidence of differences in methods

Surgical Debridement

- Treatment of choice unless contraindicated
- Needs anesthetic
  - EMLA – 1 hr before debridement
    - Cover with film to hold in place
    - As effective as Xylocaine infiltration
  - Xylocaine – check circulation before Epi
- Hemostasis
  - Silver Nitrate, Ca Alginate – Re √ in 24 hrs

When Not to Debride

- Inadequate blood flow
- Risk of deep structure exposures
- Increased medical risk for patient
- NO HEALING POTENTIAL
  - Palliative
- Medications – Prednisone
- DX - Diabetes

Topical Agents that Improve Healing Rates

- Hydrocolloid
- Transparent adhesive film
- Bacitracin zinc
- 1% silver sulfadiazine
- Benzoyl peroxide
- Polymixin B (comes in powder)
- First aid cream

Topical Agents that Can Retard Healing

- Dakin's Solution
- Hydrogen Peroxide
- Betadine
- Wet-to-dry gauze
- Triamcinolone

Increased Understanding of Chronic Wound and Infection

- Chronic wounds contaminated with skin flora
  - Enterococcus & Staphylococcus most common
- Heal in presence of bacteria
- More likely to develop MRSA
  - Treat with Bactroban topically
- Signs of infection: Increasing pain, friable granulation tissue, foul odor, & wound breakdown

Differences: Infection & Colonization

- INFECTION
- Treat with systemic antibiotics
- Topical antimicrobial agents may be useful

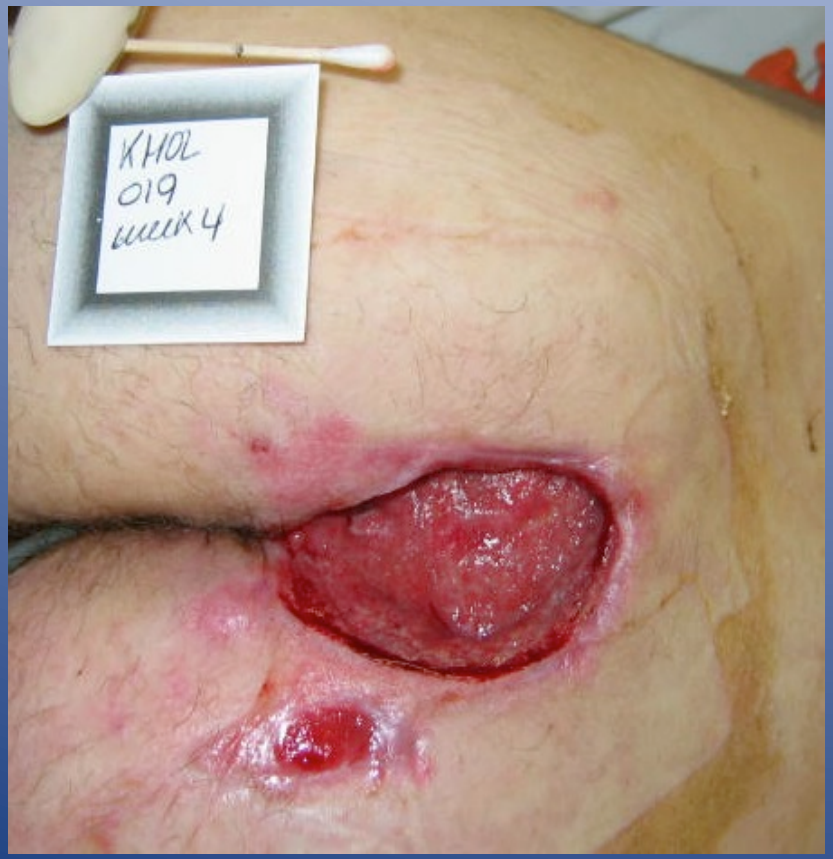
- COLONIZATION
- Topical antimicrobial agents helpful
- New agents non-toxic to fibroblast cell

Critical level of colonization can delay healing

Ulcer Care: CLEAN

- At dressing changes, with low pressure
- ***Clean with*** NS or Water – NO evidence that expensive cleansers are better
- Necrotic, infected wounds
  - Antiseptic solutions 10-14 days then **stop**- possible tissue damage
    - hypochlorite (Dakin's)--staph, strep, dissolves necrotic tissue, controls odor
    - acetic acid--pseudomonas aeruginosa in superficial wounds

Ulcer Care: TOPICAL DRESSINGS



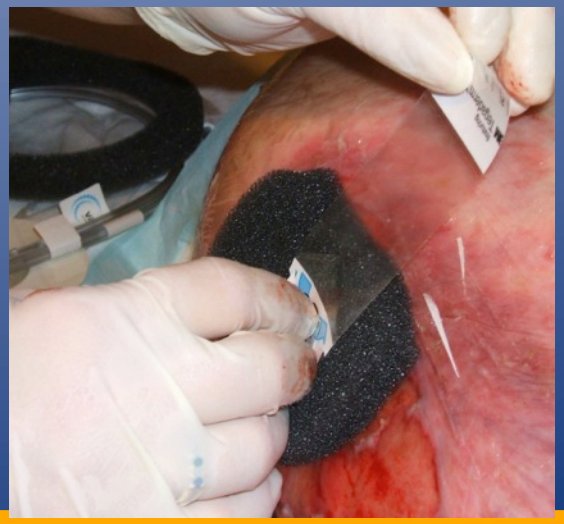
- Moist wound healing dressings ***instead*** of ***any*** form of dry gauze dressing (e.g., wet to dry or dry gauze dressing, impregnated gauze dressing)
- Use hydrocolloid dressings for stage III/IV pressure ulcers
- Use calcium alginate for wet & weeping wounds

Advanced Treatments

- Wound Vac may help in refractory wounds
- Apligraf, Regranex, Hyperbaric O2
- Compression Modalities
  - Elastic Wraps
  - Stockings
  - Unna Boots
  - Multi-Layer
  - Circ-Aid

Advanced Wound Therapy

- Increased use of negative pressure wound therapy in home and nursing home settings
- More options
  - Different suction tubes
  - Multiple companies providing the devices



In General

- Prevention is the BEST treatment!
- The best way is to prevent & manage wounds is to reduce pressure to vulnerable skin areas
- Conduct *Risk Assessment* regularly
- Manage tissue load with pressure reducing surfaces for those at risk

If Wounds are Present

- Manage tissue load with pressure reducing surfaces
- Maintain clean wound bed, manage bacterial burden
- Provide nutrition to wound bed
- Tissue tolerance factorsDocument appropriately
  - Size, characteristics, exudate, tunneling
- In presence of complex wound…
  - Eradicate necrotic areas
  - Promote moist wound healing
  - Assess & treat complications
  - Protect surrounding skin
- Communicate appropriately
- Reassess in timely fashion
- Monitor healing- PUSH tool, BWAT

Documentation

- History, assessment, treatment & progress
- Assess/reassess regularly, treat promptly, document & communicate consistently
- Document reasons for changed therapy
  - Failure to progress
  - Change of condition
- Document pain & medication
- Communicate with Responsible Party, Facility Staff & Physician

AHQR Guidelines

- Cleanse the ulcer
- Use moisture-retentive dressing
- Provide pressure-reducing surface
- Reposition 8 times per day
- Debride necrotic tissue

QUESTIONS?

FACILITY PRESSURE ULCER PREVENTION (PUP)PROGRAMS

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Disclosure

- I have no financial relationships with a commercial interest to disclose.

Acknowledgement

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Objectives

- Describe your pressure ulcer prevention (PUP) program from a patient safety perspective.
- Describe how to assess the actual PUP practices performed in your facility.
- Formulate an action plan to improve your PUP program based on findings from your self-assessment.
- Identify available resources to use in improving your PUP program.

Pressure Ulcer Prevention as Safety Goal

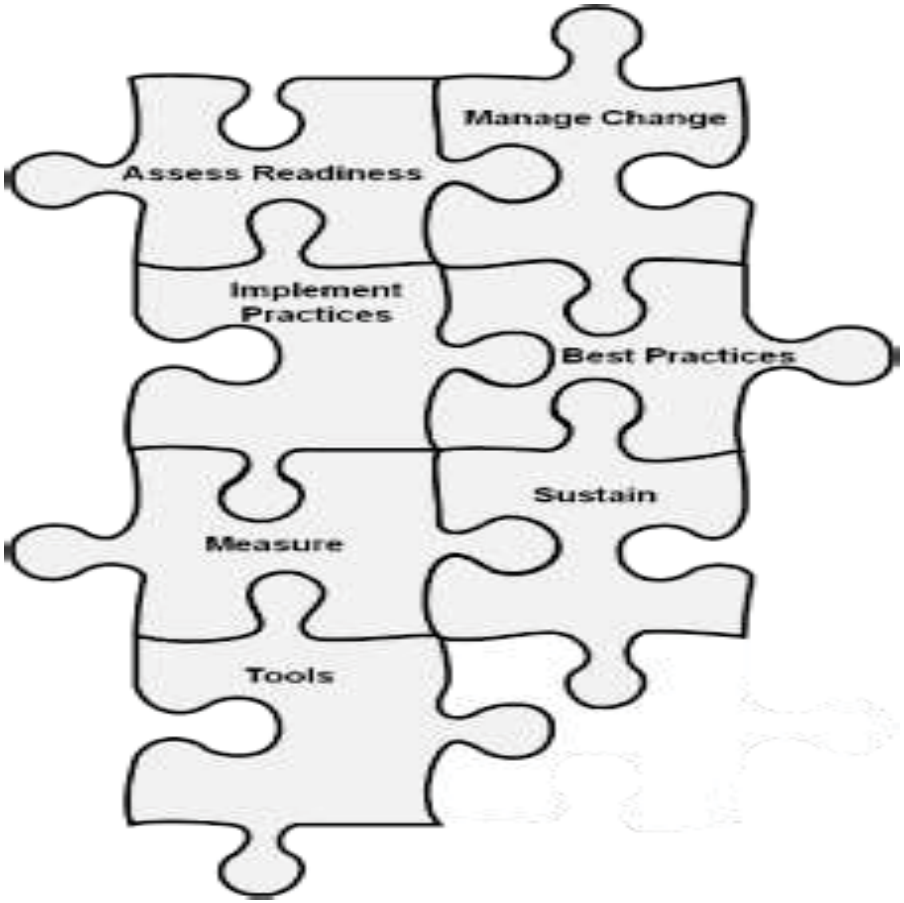
- Joint Commission National Patient Safety
  - Consumer quality marker
  - Advancing excellence

- AHRQ clinical guidelines – (1992)
- IOM – To Err Is Human (1999)
- IOM – Keeping Patients Safe – Nursing Work Environment (2003)
  - Emphasis on systems & prevention
- AHRQ Chapter 12: PUs: A Patient Safety Issue
  - Lyder & Ayello (2008)

What's the Evidence?

- Systematic review PUP safety strategies (26 studies; 8 nursing homes)
- (Sullivan & Schoelles, Ann Intern Med.2013; 158(5-Part2): 410-416)
  - Interdisciplinary team
  - Skin champions
  - Education/training
  - Risk assessment tool
  - Review wound care products
  - Upgrade information technology
  - Implement protocol
  - Patient care intervention
  - Audit and feedback

AHRQ – Key Processes of a PUP Facility Program



How to Start

- Verify what is actually going on with PUP program, remembering interpersonal nursing home safety culture principles
  - Feedback and communication
  - Supervisor and management support
  - Teamwork
  - Communication openness
  - Non-punitive responses to mistakes
  - Staffing
- Build on what you have-do not duplicate effort
  - Facility policy/procedure
  - Corporate policy/procedure
  - Advancing Excellence work
  - Any QI/QAPI processes in place
  - MDS data

AHRQ Tools & Instructions

- Views On Pressure Ulcer Prevention – staff
- Leadership Support Assessment
- Resource Needs Assessment
- Multidisciplinary Team
- Pressure Ulcer Policy Assessment
- Assessment of Screening for Pressure Ulcer Risk

AHRQ Tools & Instructions

- Assessment of Pressure Ulcer Care Plans
- Pieper Pressure Ulcer Knowledge Test (key)
- RN/CNA Pressure Ulcer Baseline Assessment (key)
- Pressure Ulcer Prevention Action Plan
- Pressure Ulcer Prevention Pathway

AHRQ Tools & Instructions

- Staff Roles – wound team and unit team
- Facility ongoing Education Assessment
- Preventing Pressure Ulcers Data Tool
- Assessing Comprehensive Skin Assessment

Assessment of Screening for Pressure Ulcer Risk

Does your facility have a process for screening that addresses all the areas listed below?

	Yes	No	Person Responsible	Comments
1. Do you screen all patients for pressure ulcer risk at the following times: • Upon admission • Upon readmission • When condition changes				
2. If the patient is not currently deemed at risk, is there a plan to rescreen at regular intervals?				
3. Do you use either the Norton or Braden pressure ulcer risk assessment tool? *If Yes, **STOP**. If No, please continue to #4.*				
4. If you are not currently using the Norton or Braden risk assessment, does your screening address the following areas: • Impaired mobility: ○ Bed ○ Chair • Incontinence: ○ Urine ○ Stool • Nutritional deficits: ○ Malnutrition ○ Feeding difficulties • Diagnosis of: ○ Diabetes Mellitus ○ Peripheral Vascular Disease • Contractures • Hx of pressure ulcers				

Assessment of Pressure Ulcer Care Plan

Does the care plan for pressure ulcers address all the areas below (as they apply)?

	Yes	No	Person Responsible	Comments
Impaired Mobility • Assist with turning, rising, position • Encourage ambulation • Limit static sitting to 2 hours at any time				
Pressure Relief • Support surfaces: Bed • Support surfaces: Chair • Pressure-relieving devices • Repositioning • Bottoming out in bed and chair*				
Nutritional Improvement • Supplements • Feeding assistance • Adequate fluid intake • Dietitian consult as needed				
Urinary Incontinence • Toileting plan • Wet checks • Treat causes • Assist with hygiene • Use of skin barriers and protectants				
Fecal Incontinence • Toileting plan • Soiled checks				
Skin Condition Check • Intactness • Color • Sensation • Temperature				
Treatment • Physician-prescribed regimen • Appropriateness to wound staging • Treatment reassessment timeframe				
Pain • Screen for pain related to ulcer • Choose appropriate pain med • Provide regular pain med administration • Reassess effectiveness of med • Assess/treat side effects • Change or cease pain med as needed				

To determine if a patient has bottomed out, the caregiver should place his or her outstretched hand (palm up) under the mattress overlay below the existing pressure ulcer or that part of the body at risk for pressure formation. If the caregiver can feel that the support material is less than an inch thick at this site, the patient has bottomed out.

Facility Assessment

Date:

A. Does your facility have initial and ongoing education on pressure ulcer prevention and management for both nursing and nonnursing staff?

___ **No**. If no, this is an area for improvement.

___ **This is an area we are working on.**

___ **Yes**.

B. Does your facility's education program for pressure ulcer prevention and management include the following components?

	Yes	No	Person Responsible:	Comments:
1. Are new staff assessed for their need for education on pressure ulcer prevention and management?				
2. Are current staff provided with ongoing education on the principles of pressure ulcer prevention and management?				
3. Does education of staff provide discipline-specific education for pressure ulcer prevention and management?				
4. Is there a designated clinical expert available at the facility to answer questions from all staff about pressure ulcer prevention and management?				
5. Is the education provided at the appropriate level for the learner (e.g., CNA vs. RN?)				
6. Does the education provided address risk assessment tools and procedures?				
7. Does the education include staff training on documentation methods related to pressure ulcers (e.g., location, stage, size, depth, appearance, exudates, current treatment, effect on activities of daily living, pressure redistributing devices used, nutritional support)?				

C. What areas of knowledge does the assessment of staff suggest need more attention in education?

Pressure Ulcer Policy Assessment

Does your facility's policy for the prevention and management of pressure ulcers include these components?

	Yes	No	Person Responsible	Comments
1. Does your hospital's policy include a statement regarding your facility's commitment to pressure ulcer prevention and management?				
Does your hospital's policy include a standard protocol for assessing a patient's risk for developing pressure ulcers?				
Does your hospital's policy state that all patients be reassessed for pressure ulcer risk at the following times: a. Upon admission b. Upon transfer c. When a change in condition occurs				
Does your hospital's policy state that a skin assessment should be performed on all patients at risk for pressure ulcers at the following times: a. Upon admission b. Daily c. Upon transfer				
Does your hospital's policy include who, how and when pressure ulcer program effectiveness should be monitored and evaluated?				
Does your hospital's policy include goals of pressure ulcer management such as: a. Prompt assessment and treatment b. Specification of appropriate pressure ulcer risk and monitoring tools c. Steps to be taken to monitor treatment effectiveness d. Pressure ulcer treatment techniques that are consistent with clinically-based guidelines				
Does your hospital's policy address steps to be taken if pressure ulcer is not healing?				

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
	Examples	**Examples**	**Examples**
4. Put the redesigned bundle into practice.	Engage staff and get them excited about the changes needed.	Team leader, unit staff	Within 12 weeks from initiative start
	Pilot test the new practices.	QI department	Within 20 weeks from initiative start
5. Monitor pressure ulcer rates and practices.	Determine how incidence and prevalence data will be collected. Tool 5A.	QI department	Within 6 weeks from initiative start
	Organize quarterly prevalence studies.	QI department	Within 6 weeks from initiative start, ongoing
6. Sustain the redesigned prevention practices.	Ensure continued leadership support.	Team leader	Within 4 weeks from initiative start and ongoing
	Ensure ongoing support from other units such as facilities management and IT.	IT, facilities management, PT, dietitians	Within 40 weeks from initiative start
	Designate responsibility and accountability for pressure ulcer prevention oversight and continuous quality improvement.	Team leader and implementation team	Within 40 weeks from initiative start

Pressure Ulcer Prevention Action Plan

Date: February 16, 2011

Improvement Objective: Implement standard pressure ulcer prevention practices within 6 months

Key Interventions/Tasks	Steps To Complete Task and Tools To Use	Team Members Responsible for Task Completion	Target Date for Task Completion
	Examples	**Examples**	**Examples**
1. Analyze current state of pressure ulcer prevention practices in this organization.	Identify strengths and weaknesses using process mapping and gap analysis. Tool 2C and Tools 2E-2G.	Team leader, RNs, and WOCNs	Within 6 weeks from initiative start
	Assess the current state of staff knowledge about pressure ulcer prevention. Tool 2H.	Education department	Within 6 weeks from initiative start
	Set target goals for improvement.	QI department	Within 8 weeks from initiative start
2. Identify the bundle of prevention practices to be used in redesigned system.	Determine how comprehensive skin assessment should be performed	Wound care team	Within 12 weeks from initiative start
	Decide which scale will be used for performing risk assessment.	Wound care team	Within 12 weeks from initiative start
	Decide what items of pressure ulcer prevention should be in your bundle	Clinical staff members	Within 12 weeks from initiative start
3. Assign roles and responsibilities for implementing the redesigned pressure ulcer prevention practices.	Examples	Examples	Examples
	Determine who will complete the daily skin and risk assessments. Tool 4A.	Implementation team	Within 16weeks from initiative start
	Identify unit champions.	Team leader	Within 16 weeks from initiative start
	Determine how prevention work will be organized at the unit level, such as paths of communication and lines of oversight.	QI team	Within 16 weeks from initiative start

Action Planning Session

Wound Care

Disclosures

Dr. Bakerjian is on the National Advisory Board for Omnicare Pharmacy, and a Member of the National Quality Forum of Common Formats

No other faculty or planners have any relevant financial relationships with a commercial interest to disclose.

Activity planners have resolved the potential conflict of interest and determined the presentation is without bias.

Learning Objectives

- Decide on a measureable objective for improving wound care
- Identify the core members at your facility who will Champion and Co-champion this quality improvement project
- Decide what care processes you will initially address
- Establish a timeline for completion of the initial intervention
- List the top 3 barriers you will need to address to move forward with this quality improvement initiative

Q & A Panel
Wound Care

Debra Bakerjian, PhD, RN, FNP, FAANP;
Mary Ellen Dellefield, PhD;
David J. Farrell, MSW, LNHA;
James Jordan

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Learning Objectives

- Using QAPI concepts, the facility leadership team will make observations to identify a subset of patients at greatest risk for developing a wound
- Using the INTERACT planning tool, the team will analyze and synthesize wound information from multiple sources
- Apply QAPI concepts to relate cause and effect of wound development
- Develop a tracking tool to measure the wound status of every patient upon admission and at appropriate intervals thereafter
- Facility leadership team will develop a communication data platform to inform and engage the participation of all caregivers