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"Effective Professional Interaction Among Medical Director, Director of Nurses and Consulting Pharmacist in the Nursing Home Environment"

The Art and Science of Infection Prevention & Control
May 17-18, 2017

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Joe Boero MD, Paula Kock RN, and Angela Studnicka PharmD report no financial conflict of interest related to the material presented today

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Attendees will learn…

- The vital role of the DON, both as a leader and a coordinator, to pursue a strong working relationship between DON, medical director and consulting pharmacist in the long term care environment.
- The roles and responsibilities of the medical director and how these may be leveraged to solve clinical problems and improve quality of the antibiotic stewardship program.
- Duties of a consultant pharmacist within a nursing home and his/her role related to the implementation of an antibiotic stewardship program.

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DIRECTOR OF NURSING

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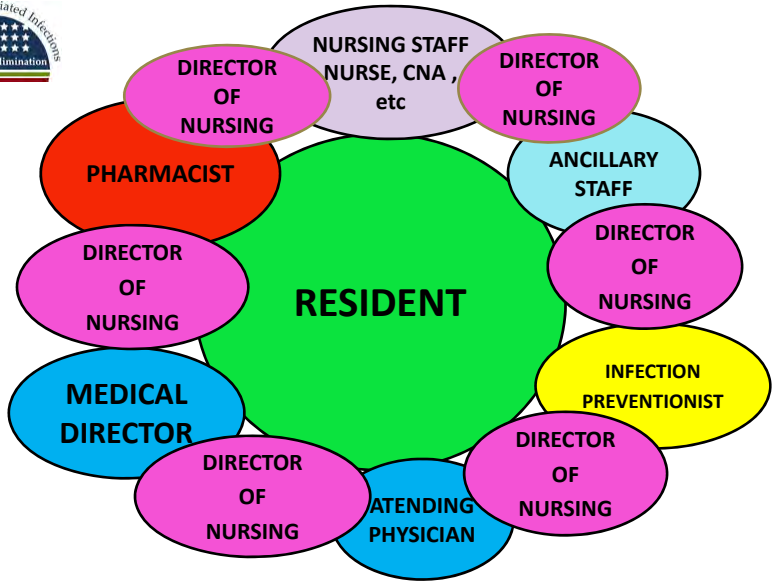

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Role of DON

- **BE A LEADER AND A PARTNER**
- **Being a leader is both a position and a process** all facilities have a leader, but many are not effective
- **Build a team**

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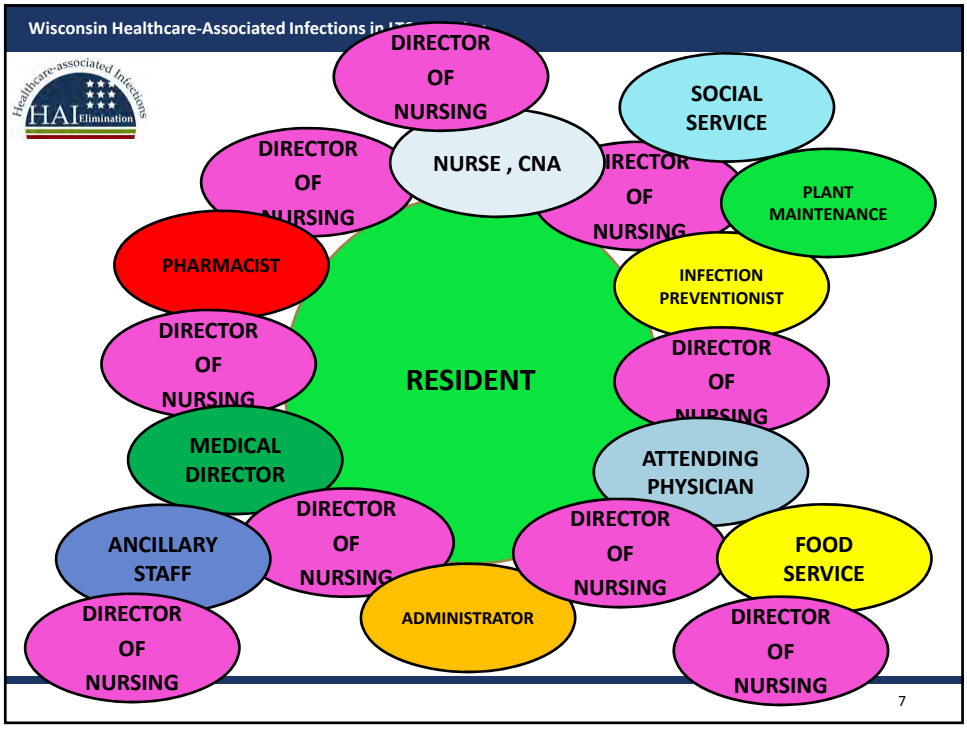

Roles of DON

- Assumes authority and accountability for delivery of nursing service
- Prepares annual budgetary goals for nursing department and maintains the operating budgets
- Interviews and hires nursing staff

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Roles of DON

- Develops and implements policies and procedures to meet State and Federal guidelines
- Assures compliance with regulations pertaining to care plans and resident assessments
- Collaborates with contracting providers (Rehabilitation, Speech Pathology, Tele-Health, Laundry, etc.) to enhance resident quality of care.

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Roles of DON

- Monitors job performance of the nursing staff
- Assumes liaison roll between facility and residents, families, significant others, staff and the general public
- Prepares nursing staff for CMS certification and leads them through state survey process

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Roles of DON

- Coordinates overall care of resident among direct care staff, charge nurses, attending physician, consultant pharmacist and medical director
- Screens prospective residents to assure that staff has resource and ability to provide needed care
- Implements infection control program, pharmaceutical policies and procedures

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Roles of DON

- Assures that consultant pharmacist's medication review recommendations from are noted and acted upon by attending physician.
- Keeps medical director and consultant pharmacist informed about what is going on…..

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Overarching Functions of DON

- Be involved.
- Be available.
- Be a team member and leader.
- Be informed of resident changes in condition

TAKE THE LEAD IN ANTIBIOTIC STEWARDSHIP

- Utilize your resources, i.e.: medical director and pharmacist
- Assure the medical director and consultant pharmacist are informed
- Enlist the medical director and consultant pharmacist as a collaborative team with the DON

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TAKE THE LEAD IN ANTIBIOTIC STEWARDSHIP

- Educate everyone, tell everyone, follow through
- Review, revise and re-implement
- Audit and analyze data
- Utilize consultant pharmacist-right drug, right dose, right duration
- Utilize medical director to help manage infectious disease in the facility to ensure appropriate use of antimicrobial agents in the facility

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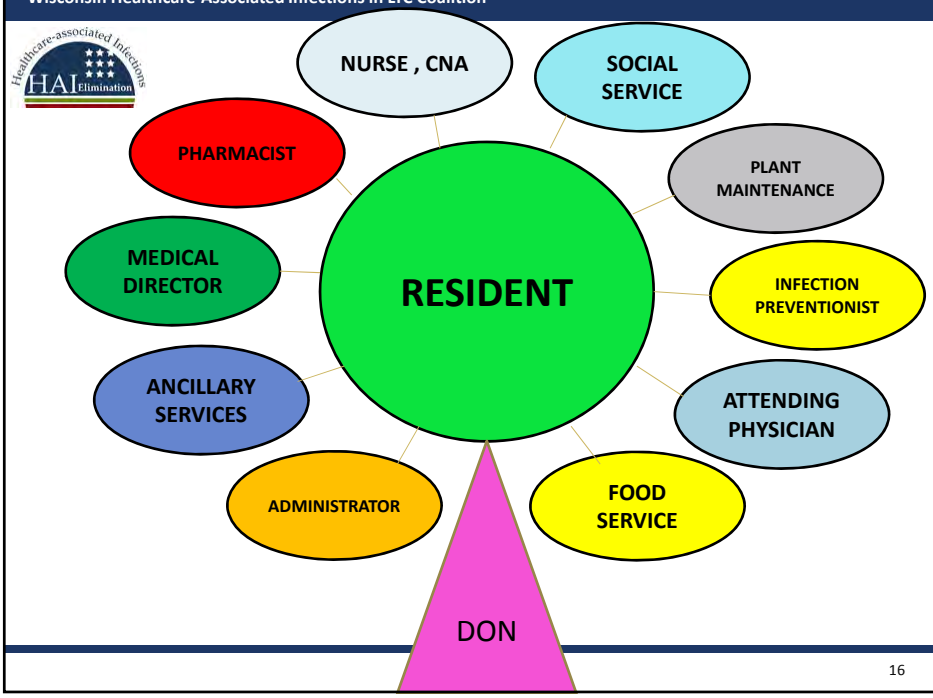

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MEDICAL DIRECTOR

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Objectives

1. Development of the role/responsibility of Medical Director
2. Functions and tasks of the Medical Director
3. Strategies to effectively use the Medical Director

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1. Developing Role of Medical Director

- 1974-Medicare said "The Medical Director should be responsible for the medical care of the residents of the facility."
- 1987-OBRA ➡ March 1991, AMDA approves "Roles and Responsibilities of the Medical Director in Nursing Homes."

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1. Developing Role of Medical Director

- 2001 Institute of Medicine report-"Improving Quality of Long Term Care" urged facilities to give Medical Directors greater authority and accountability.
- Also, NH should develop structure and policy to "enable and require" a more focused and dedicated staff through credentialing, peer review, and accountability to the Medical Director.
- April 2002 AMDA revises 1991 "Roles and Responsibilities…" to clarify Medical Director's oversight of care to the increasingly complex, frail and medically challenging nursing home population. (This revised in 2011*)

* AMDA White Paper A-11 20

Medical Director's Role F-Tag 501

- "The Medical Director helps the facility identify, evaluate and address /resolve medical and clinical concerns and issues that affect resident care or quality of life related to provisions of services by physicians and other licensed health care providers"
- This oversight, consultative, administrative function is distinctly separate from his clinical care of his personal residents in the facility.

S&C 5-29 June 5, 2005

Compliance with F-501

- There must be a Medical Director who is a licensed physician
- The survey team must identify whether noncompliance at other tags relates to the Medical Director Role.
- The team must show association between the identified deficiency and failure in medical direction.
- This does not presume that a facility's noncompliance…necessarily reflects on the performance of the Medical Director.

Monthly Medical Director Report

Monthly Medical Director Report
Park Manor Nursing Home
April 2017

Date	Involved Parties	Discussion	Time
April 3, 2017	Sharon, Paula	Monday afternoon phone call. Review state of facility, discussed letter to employees thanking them for performance of duty to manage recent Influenza outbreak, reviewed facility menu and food service plan. Discussed my intention to resign medical directorship in October 2017. Arranged plan to visit facility on April 18, 2017	20 min
April 4, 2017	Ginny	E-mail exchange about plan for influenza immunization program once vaccine outdates.	10 min
April 4,2017		Composed and sent letter to employees expressing thanks in successful management of March Influenza outbreak and also letter of resignation	1 hr
April 7, 2017	Heidi, Paula, Deb, Sharon	E-mail review and discussion with suggestions of revised med error work-sheet and process	1 hour
April 6, 2017 (late)	Paula	Phone call: Informed about resident with RSV cough on one wing. Reviewed Isolation measures	10 min
April 10, 2017	Paula	Set up monthly visit for April 18. And Board meeting on May 2, 2017	5 min

Roles-the set of expected and obligatory actions

- **Physician Leadership**-responsibility for overall care and clinical practice carried out by the facility.
- **Patient Care/Clinical Leadership**-application of clinical and administrative skills to guide the facility in providing care.
- **Quality of Care**-helping facility manage quality, safety, and risk management initiatives.
- **Education**-providing information and experience to staff, providers and the community to understand and provide care.

2. Functions and Tasks of the Medical Director

Functions – are the major domains of action within a role and are embedded in the overarching roles of the Medical Director and represent foundations for developing tasks to carry out the roles of the medical director.

Tasks – are the special activities that are undertaken to carry out Functions

9 Medical Director Functions

1. Administrative 6/2
2. Professional Services 7/9
3. Quality Assurance & Performance Improvement 6/6
4. Education 4/4
5. Employee Health 2/7
6. Community 1/6
7. Rights of Individuals 4/4
8. Social, Political, Economic Factors 2/4
9. Person Directed Care 3/3

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So Many Tasks…

There are 35 Tier 1 tasks and 45 Tier 2 tasks listed in the A-11 AMDA white paper to cover the nine Functions

For example: "The medical director advises on admission screenings and transfer"

Others are: "The medical director develops…, helps establish…, helps support…, helps assure…, helps ensure…, advises on…, helps with policies on…, advises regarding…, develops and reviews…, organizes, develops and co-ordinates…, collaborates with…, guides administration on…, helps facility arrange for…,

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3. Strategies to effectively utilize your Medical Director to improve quality

Just ask…

but follow through

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Engage Your Medical Director

- Define QA projects with input of the Medical Director
- Tell EVERYBODY what you're doing
- Ask you Medical Director to author letters to Medical Staff
- Invite the Medical Director to attend Survey exit
- Give the Medical Director policy book for review
- Notify the Medical Director of critical incidents
- Engage the Medical Director as consultant to review critical incidents of care

Engage…

- Ask Medical Director to deliver in-service education.
- Do walk around to meet the CNAs, kitchen staff, maintenance dept.
- Support membership in AMDA/WAMD and go to the meetings together
- Encourage CMD certification
- Be attuned to young physician staff and mentor for the next generation of Medical Directors
- If the fit is not satisfactory, fire your Medical Director or get an assistant Medical Director

CONSULTANT PHARMACIST

Consultant Pharmacist Role

- 42 CFR 483.45 Pharmacy Services

  (a) Procedures. A facility must provide pharmaceutical services to meet the needs of each resident

  (b) Service consultation. The facility must employ or obtain the services of a licensed pharmacist who:

  - (1) provides consultation on all aspects of the provision of pharmacy services in the facility

Consultant Pharmacist Role

- This includes, but is not limited to, collaborating with the facility and medical director to:
  - Develop/implement/evaluate/revise procedures for provision of pharmaceutical services
  - Coordination of pharmaceutical services if and when multiple providers are used (i.e. hospice, IV pharmacy, PDP)
  - Develop IV therapy procedures, including staff training and competency

Role Continued

- Determine contents of contingency, monitor use, and replacement
- Strive to assure medications are requested, received, and administered in timely manner
- Provide feedback related to medication administration and medication errors
- Participate in the interdisciplinary team

Consultant Pharmacist Role

- 42 CFR 483.45 Pharmacy Services
  - (c) Drug regimen review (DRR)
    - (1) ….each resident must be reviewed at least once a month by a licensed pharmacist
    - (2) *the review must include a review of the resident's medical chart*
    - (4) …report any irregularities to the attending physician and the facility's *medical director* and director of nursing

Drug Regimen Review, cont.

- Consultant pharmacist along with facility should establish procedures for:
  - Conducting the monthly DRR
  - Outlining time frames for conducting the review and reporting the findings
  - Outlining steps the pharmacist must take when an irregularity is identified, including time frames
  - Documenting the results of the DRR
- Ensure process is established for short stay residents or those with change in condition

Consultant Pharmacist Role

- 42 CFR 483.45 Pharmacy Services

  (d) Unnecessary Drugs. Each resident's drug regimen must be free from unnecessary drugs.

Unnecessary Drug, cont.

- Any drug when used:
  - In excessive dose
  - For excessive duration
  - Without adequate monitoring
  - Without adequate indications for use
  - In the presence of adverse consequences which indicate the dose should be reduce or discontinued
  - Any combination of the reasons above

F-Tags and Pharmacy Services

- F425 – 483.45 Pharmacy Services
  - To be compliant facility must provide or arrange for:
    - Resident to receive medications and/or biologics as ordered by prescriber
    - Development and implementation of procedures for pharmacy services
    - Services of pharmacist who provides consultation
    - Personnel to administer medications consistent with applicable state law and regulations

F-Tags continued:

- F431 – Drugs Storage, Labeling, Inventory
  - 483.45(b) Service Consultation
  - 483.45(g) Labeling of Drugs & Biologics
  - 483.45(h) Storage of Drugs & Biologics

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F-Tags continued:

- Facility compliant if:
  - Safeguarding medications by locking, limiting access, and appropriate disposal
  - Medications properly stored
  - Medication labeling includes minimum identifiers
  - CII medications stored separately
    - Locked, permanently affixed compartments
  - Controlled medications reconciled accurately

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F-Tags continued:

- F428 – 483.45(c) Drug Regimen Review
  - To be compliant:
    - Pharmacist must conduct DRR on each resident at least monthly or more frequently depending on condition
    - Pharmacist identifies irregularities and notifies DON, medical director, and attending physician
    - Report of irregularities must be acted upon

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F-Tags continued:

- F329 – 483.45(d): Unnecessary Drugs
  - Facility must assure medication therapy based upon:
    - Adequate indication for use
    - Appropriate dose used
    - Provision of behavioral therapies/GDRs for those on antipsychotics
    - Appropriate duration of use
    - Adequate monitoring to ensure goals are met & adverse events detected (& dose reduced/stopped)

F-Tags continued:

- F329: antibiotic-related issues
  - Prophylactic use to prevent UTI
  - Initiation of antibiotic without urine testing (UA or culture)
  - Antibiotic therapy not modified following:
    - Negative cultures
    - Resistant susceptibility results
  - Diagnosis of infection not supported by s/s
    - Asymptomatic bacteriuria, non-localized symptoms

Consultant Pharmacist & Antibiotics

- CDC Core Elements
  - Review of antibiotics as part of the DRR
    - Dosing & administration
    - Renal function
    - Drug interactions
    - Indication and justification
    - Culture & sensitivity review

Case 1: 101 y/o female with rash

- Long term resident, LS, develops chronic blistering dermatitis
- Exam: frail elderly alert female. Wt: 108#, BP 110/70, afebrile, SCr 1.9 mg/dL. Non-dermatomal rash with 2-15 mm. clear fluid filled blisters.
- PCP refers for TeleHealth Derm consult
  - Dermatologist starts Minocycline 50mg BID for 2 weeks and re-check

Case 1, continued:

- Blisters worse, crusty and cultured
  - Culture report identifies MRSA with doxycycline & clindamycin resistance
- Dermatologist continues minocycline and adds Prednisone 15mg daily for 2 weeks and re-check
  - Crusts gone, no new blisters, continue minocycline with prednisone taper 1mg/day/week

Case 1, continued…

- Meanwhile, male resident friend across the hall with hx O2 dependent COPD develops a scalp boil
  - Cultured positive MRSA resistant to doxycycline & clindamycin.
- Three months later, resident develops febrile purulent unilateral parotitis
  - PCP notified, examined, serologic test for MUMPS IgG (pos), IgM (neg)

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Case 1, continued:

- Push fluids, Narcotic analgesic, empiric Clindamycin 300mg QID initiated
- Resident deteriorates and family requests no hospitalization and comfort care
  - Resident expires in four days

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Case 2: C. Diff.

- On 1/19/2017, an elderly male is admitted to the NH following a recent fall on 1/7/2017 with pelvic fracture and large pelvic hematoma
- PMHx: Paroxysmal Afib (not on anticoagulation), mitral insufficiency, BPH, Stage 4 CKD, HTN, hypothyroidism
- Hospital DC summary indicates resident felt to have pelvic hematoma which contributed to urinary retention and urethral catheter placed 1/9/17
  - To remain 10-14 days to allow hematoma improvement before attempted voiding trial

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Case 2, continued…

- ROS: TSH elevated in hospital (Levothyroxine increased), BP elevated in hospital (terazosin added for BP/BPH), no history of bladder infections, allergy to Sulfa (nausea)
- Exam: elderly male in NAD but with intermittent anxiety/tearfulness, oriented x3, wt: 174.2#, ht: 72", BP 140/61, pulse 62, afebrile, SCr 1.75 mg/dL (baseline 1.5-1.6 mg/dL)
- Meds: APAP routine, hydralazine, levothyroxine, allopurinol, amiodarone, amlodipine, ASA, buspirone, Vitamin D, sertraline, Vitamin B12, analgesic balm, terazosin (newly initiated in hospital)

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Case 2, continued…

- Nursing home Course: Resident admit to NH on 1/19/2017 and seems motivated for physical and occupational therapy.
- On 1/23/2017, to Urology Clinic where catheter was removed for voiding trial and resident returned with following orders:
  - Continue Terazosin
  - Start Ciprofloxacin 500mg BID for 3 days to prevent UTI following catheter removal (no UA)
  - Toilet every 2-3 hours for next 48 hours. If unable to void after 8 hours, staff to complete bladder scan and if >500mL straight cathx1, continue bladder scan if no void and replace urinary catheter.

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Case 2: continued…

- On 1/27/2017, following completion of Ciprofloxacin course, resident noted to have developed watery stools
  - Stool cultures on 1/28/2017 returned positive for C. diff toxin A on 1/30/2017
- Resident started on Metronidazole 500mg TID for 14 days for C. diff on 1/30/2017
  - Stools returned to normal after 3 days of therapy
- Remainder of NH stay insignificant and resident discharged to local ALF on 2/9/2017

Case 3: ILI outbreak

- On 3/2-3/17, nine residents in two units develop non-productive cough with fever, myalgia and body aches
- NP viral swabs are sent on eight residents
  - 1 negative
  - 3 positive for Influenza A
  - 3 positive for Influenza B
  - 1 positive for RSV

Case 4: Antibiotic Prescriber Outlier

- During a monthly QA meeting, the Infection Preventionist makes the statement:
  - "Dr. Trieshard's nurse practitioner automatically treats EVERY resident with a cough with a Z-pak. She gives us a diagnosis, BRONCHITIS, for antibiotic indication."

Questions/Discussion

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