Libby Youse, LNHA has over 20 years' experience as a licensed administrator of skilled nursing homes. She graduated from Hannibal LaGrange University (Hannibal LaGrange College) with an emphasis in business and continues her adult learning education at the University of Missouri. Libby started her career as a nurse’s aide (back in the dark ages—before they had to be certified). Libby has served in homes as an effective Administrator—showing leadership in developing Quality and Performance Improvement (QAPI) teams, regulatory compliance resulting in good survey outcomes, working with staff in understanding quality measures, proficiency in management, financial accountability and has experience in implementing, encouraging, and developing Culture Change.

In June 2016 Libby began a new journey in life working for the Sinclair School of Nursing, University of Missouri and serves as a Long-Term Care Leadership Coach. Libby can help administrators and their teams to identify and implement tools and systems for continuing to improve the quality care that all Missouri Seniors deserve. Libby is available to assist with education through personal site visits and consultations with email or phone. She can also assist homes with mock surveys to help them have better outcomes and to assist them in learning and understanding nursing home regulations.

Libby served on the board of Missouri Health Care Association (MHCA) from 2011 to 2016. She also served as the MHCA District VI President and as that District’s Vice-President and Treasurer. She received the David Duncan Administrator of the year for MHCA District VI in 2012, 2014 and 2015. Libby received the Missouri Health Care Member of the Year award in 2015 and the AHCA/NCAL National Quality Award in 2015.

If you need her services, please contact her at youseme@missouri.edu or by telephone at (660) 651-3778.
Dear Friends,

For 5 years I have been privileged to work with QIPMO on behalf of the Sinclair School of Nursing, University of Missouri. After working 46 years in LTC, I have been fortunate to meet many wonderful and amazing people - co-workers, residents, surveyors, government servants, trade organizations, and family members. However, with mixed emotions it is time for me to retire - my last official day was June 30, 2016.

As you can imagine, the decision to leave QIPMO was difficult. During my tenure, I have been privileged to become acquainted with countless passionate caring colleagues who have enriched my life both personally and professionally.

It has been a privilege to be the first LTC Leadership Coach in the state and the only one for the first three years of my tenure. As I traveled the state, I knocked on doors, made cold calls, and built relationships. I developed a FREE Survey Readiness Manual (nursinghomehelp.org/coaching.html) and was the first to offer “mock survey” so that homes could improve their survey outcomes. Throughout my long career, I’ve been actively involved with the Missouri Health Care, Missouri Association of Nursing Home Administrator (MANHA), Missouri League of Nursing Homes (MLN), Missouri Coalition Celebrating Care Continuum Change (MC5), and many others.

I am proud of my accomplishments, and I know my replacement and the QIPMO team will continue to provide leadership and assistance as needed across the state to improve the opportunities for older adults to live healthy, happy, and person-centered lives.

I thank ALL the people who have touched my life in some way during my professional career with your kindness, caring, expertise, and professionalism. I have mentored and been mentored by many of you, worked with some, laughed, struggled, and stressed with the others. I will have the fondest memories of the people I’ve had the opportunity to touch and be touched in some way.

Thanks for the memories!

Dave
Antithrombotic drugs in routine use are to treat and to prevent blood clotting formation, thus to treat or minimize the risk of heart attack and stroke caused from a thrombosis condition. They are also known by the term “blood thinner.” There are two classes of antithrombotic drugs: anticoagulants and antiplatelet drugs. Because of their similar indications, they are often being confused for coding on the MDS 3.0, under section N 410E.

To facilitate the MDS coordinators in coding this section, the chart on page 3 categorizes these antithrombotic drugs into different classifications. Whether the drug is an anticoagulant or an antiplatelet agent, routine monitoring is best nursing practice to prevent potential injury.

**Potential side effects or adverse reactions are thrombocytopenia and increased risk of bleeding. Anticoagulants require more intensive monitoring process with laboratory testing (PT and INR), while antiplatelet can be less intensive monitoring process from nursing care, observation, screening and assessments. Care plans should address the risk for injury along with care interventions. In addition, other professionals such as pharmacist, physician and dietician should be consulted for drug-to-drug interactions and food-to-drug interactions to ensure the safe practices.**

**Resources:**
[drug.com](https://www.drug.com); RAI manual
Moving up from the third spot back into the number two spot for the Most Frequently Cited Deficiencies from January 1, 2016 to March 31, 2016, with 67 citations is F441. In fact, F441 has ranked second in the Most Frequently Cited Deficiency Report in Missouri for seven out of the eight previous quarters.

Common infections among the long-term care population include, urinary tract, upper respiratory, and soft tissue infections. Infection control is an area where non-compliance can have significant impact on the quality of life for a long-term care resident. The elderly have a higher risk of death and complication from infections; therefore it is no surprise that F441 continues to be a focus area of surveys. According to the Centers for Disease Control and Prevention (CDC) regarding infections in long-term care facilities:

- 1 to 3 million serious infections occur every year in these facilities.
- Infections include urinary tract infection, diarrheal diseases, antibiotic-resistant staph infections and many others.
- Infections are a major cause of hospitalization and death; as many as 380,000 people die of the infections in LTCFs every year.

§483.65 Infection Control Appendix PP (SOM) says that:

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

§483.65(a) Infection Control Program

The facility must establish an Infection Control Program under which it –

(1) Investigates, controls, and prevents infections in the facility;

(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

(3) Maintains a record of incidents and corrective actions related to infections.

§483.65(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

§483.65(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

INTENT: (F441) 42CFR 483.65 Infection Control

The intent of this regulation is to assure that the facility develops, implements, and maintains an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will:

- Perform surveillance and investigation to prevent, to the extent possible, the onset and the spread of infection;
- Prevent and control outbreaks and cross-contamination using transmission-based precautions in addition to standard precautions;
- Use records of infection incidents to improve its infection control processes and outcomes by taking corrective actions, as indicated;
- Implement hand hygiene (hand washing) practices consistent with accepted standards of

continued on page 5
practice, to reduce the spread of infections and prevent cross-contamination; and

- Properly store, handle, process, and transport linens to minimize contamination.

Residents overall health will contribute to their susceptibility of acquiring infections. For this reason, it is important that a facility take the necessary precautions when performing care giving task that have a potential to spread infections. Proper handwashing is the most effective way to prevent the spread of infection in any health care setting. Handwashing or the lack there of, also provides the most opportunities for citation.

Deficiencies in Missouri for F441 from January 1, 2016 to March 31, 2016 include the following examples:

**Handwashing/gloving/perineal care** Aide helped change resident from soiled brief to clean brief. Aide kept on soiled gloves while helping resident into clean clothing; facility staff failed to change gloves and wash hands during the provision of care to prevent the spread of bacteria and other organisms; staff did not wash their hands and change their gloves when going from a soiled area to a clean; aide did not wash hands after removing soiled gloves and continued providing care; staff failed to keep a clean wash cloth used for resident perineal care from touching the basin of a sink; facility staff failed to follow infection control measures by failing to wash their hands before and/or after providing perineal care and removing soiled gloves before touching clean objects; facility staff failed to ensure infection control measures were appropriately followed when staff put a soiled brief directly on the floor while providing care for resident; CNA wiped feces from the resident’s rectal area using one wipe, then repeated with another wipe. Feces were visible on the wipe and on the index finger of CNAs glove. CNA proceeded to wipe over the open Stage II pressure ulcer on buttocks, then discarded the wipe and put a clean brief on the resident without removing his/her soiled gloves.

**Blood glucose testing/Tuberculosis testing** Failed to provide documentation that a two-step tuberculosis skin test was completed on resident; facility failed to clean the glucometer between residents; facility failed to provide tuberculosis testing for newly admitted residents; facility failed to ensure infections control measures were followed to prevent cross-contamination and follow standard precautions during the performance of routine testing of residents blood glucose levels, by not properly cleaning, disinfecting, labeling and storage of the blood glucose machine; used alcohol pad not approved bleach solution to clean glucose testing machine between residents; infection control practices were not followed when staff failed to sanitize the glucometer, failed to sanitize the resident’s finger prior to using the lancet to obtain the blood sample; Registered Nurse put on gloves, checked Resident A blood sugar and set the glucometer on the arm of Resident A’s chair. RN brought the glucometer out of the room, did not sanitize the glucometer to prevent the spread of infection, continued to wear the same contaminated gloves, and touched the Medication Administration Record (MAR) book. RN continued to wear the same contaminated gloves, checked Resident B’s blood sugar, and put the glucometer on the resident’s pillow. RN left the room with the glucometer, and did not change gloves, wash hands, or sanitize the glucometer. While wearing the same contaminated gloves, RN entered Resident C’s room, placed the glucometer on the resident’s bed, then checked his/her blood sugar and administered insulin. RN did not change gloves, wash hands, or sanitize the glucometer. RN did not change gloves or wash hands before or after he/she administered the injection; did not document the results of resident tuberculosis skin tests (TBST), or did not document results in millimeters (mm) according to their facility policy and long term care guidelines.

**FACTORS ASSOCIATED WITH THE SPREAD OF INFECTION IN NURSING HOMES (APPENDIX PP):**

**Individual Factors:**

- Medications affecting resistance to infection such as corticosteroids and chemotherapy;
- Coexisting chronic diseases (e.g., diabetes, arthritis, cancer, COPD, anemia);
- Complications from invasive diagnostic procedures such as skin or bloodstream infections;

*continued on page 6*
Impaired responses to infection (e.g., cell mediated responses); and
Increased frequency of therapeutic toxicity (e.g., declining kidney and liver function).

Institutional Factors:
Pathogen exposure in shared communal living space (e.g., handrails and equipment);
Common air circulation;
Direct/indirect contact with health care personnel/visitors/other residents;
Direct/indirect contact with equipment used to provide care; and
Transfer of residents to and from hospitals or other settings.

The above is not an all-inclusive excerpt from F441, Appendix PP; it only highlights some of the main points outlined in the guidance. We encourage you to review the entire regulation which details a facilities responsibility regarding infection control and a proper infection control program. A systems approach is an excellent way to evaluate the effectiveness of the infection control program in a facility. Monitoring and tracking infections provides a facility the opportunity to identify trends and opportunities for improved infection control standards. Ensuring staff are educated on acceptable infection control standards and providing visual cues that reinforce the importance of handwashing are just a few ways to reduce the prevalence of infections in a facility.

Resources:
Advancing Excellence - [https://www.nhqualitycampaign.org/default.aspx](https://www.nhqualitycampaign.org/default.aspx)

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**Prioritizing Individuals Who Will Benefit From Antipsychotic Reduction**

Sharon Thomas, BSN, RN, RAC-CT ♦ QIPMO Educator

Atypical antipsychotic drugs are being overprescribed for elderly residents with dementia in long-term care, and the side effects include an increased risk of death. Though the FDA includes that warning in a black box about the drugs, a 2011 Office of Inspector General (OIG) report found a high percentage of Medicare claims for such drugs in elderly nursing home residents with dementia. The report is available at [oig.hhs.gov/oei/reports/oei-07-08-00150.pdf](http://oig.hhs.gov/oei/reports/oei-07-08-00150.pdf).

The OIG report prompted the Centers for Medicare & Medicaid Services (CMS) to launch a National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes in 2012.

Atypical antipsychotics are often prescribed for elderly persons with dementia to manage their symptoms. In addition to the OIG, the use of antipsychotic medication for the management of behavioral symptoms has come under fire by many geriatric professionals. The management of symptoms by non-pharmacologic means is being encouraged and is showing positive results.

As part of the effort to decrease the use of
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As part of the effort to decrease the use of antipsychotics in nursing homes, the partnership is working to provide resources to improve services for non-drug dependent persons with dementia. CMS developed the Hand-in-Hand Toolkit. The training material, mailed to every U.S. nursing home, emphasizes person-centered care. The kit contains training modules that focus on communication, abuse prevention, and high-quality care for elders. The modules, which include video clips, are intended to help care partners develop the necessary skills to work with persons who have dementia and to help each individual maintain a high quality of life. Those who cannot find their Hand-in-Hand Toolkit can download it at www.cms-handinhandtoolkit.info/Index.aspx.

CMS also emphasizes the use of non-pharmacological alternatives for residents. Examples of non-pharmacological interventions include consistent assignment, increased activities, the Music and Memory program, art therapy, or better management of pain. Any approach must be individualized and tailored to the current needs of each resident. Interventions must be recorded in care plans and updated as needed.

The most recent data from the partnership details progress. Nationally, in 2011Q4, 23.9% of residents in long-stay nursing homes received antipsychotic medication. In 2015Q3, the percentage decreased to 17.4%. In Region 7, which includes Kansas, Iowa, Nebraska, and Missouri, the rate dropped from 24.5% to 18.8%. Missouri’s rates went from 26% to 19.33%, a reduction of 26 percent. Despite this drop, Missouri is 39th in the nation for antipsychotic usage. The data comes from the CMS Quality Measure data based on the Minimum Data Set (MDS) 3.0 assessments. Those with a diagnosis of schizophrenia, Huntington disease, or Tourette syndrome are excluded from the measure. It should be noted that the Quality Measure does not reflect gradual-dose reductions, which are often necessary to safely eliminate a medication from an individual’s medication regime. The MDS only shows if a person is taking a drug. That being said, many homes are actively working to decrease dosages with the ultimate goal of total elimination.

The new “Antipsychotic Reduction, Resident Priority Tool” may also help reduce antipsychotic usage. The tool (on the following pages) was developed by Telligen, a Medicare Quality Innovation Network Quality Improvement Organization, under contract with CMS. The tool will help identify and prioritize individuals who should be considered for gradual dose reduction (GDR). Part 1 asks a series of questions that begin with ensuring the diagnosis in a chart matches the MDS. The next question reviews the dosage and administration schedule and assesses for attempts at gradual dose reduction. Part 2 provides a guide in determining the high-priority, gradual-dose reduction residents. Please look at the tool and consider how it can help your efforts at eliminating antipsychotic

continued on page 8
medications for residents with dementia in your home. It is available at
www.hsag.com/contentassets/a94cac2292914df2bef9611b42c1f177/antipsychotic-
reduction-tool_508pubbed.pdf.

Your QIPMO nurse is available to assist you in utilizing this tool and continuing your efforts to find non-
pharmacologic methods to support residents who struggle with dementia. Remember that “problematic”
behavior exhibited by residents with dementia may really be their way of communicating. As we learn to
“hear” what residents are telling us, we will be better able to utilize their strengths to meet their desires
and needs. This will enable them to live life to the fullest and will give staff a great feeling of satisfaction.

For more information on the partnership and survey guidance related to nursing home residents with
dementia and unnecessary drug use, please review the S&C memo dated May 24, 2013.
www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-
Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html (see appendix A)

We all dread that call we get in the middle of the night because it usually means bad news. But
there’s a world of people who don’t have anyone to call. People who have to leave that call-in-case-of-
emergency spot blank. People who sit in the back rooms of the ER and sometimes share names like
JOHN DOE.

We all know that lady who only buys cat food and Half & Half at ALDI. Or the guy with the scraggly
beard who slips out of the back pew just before the end of services, or the boy who talks a little funny,
walks a little crooked, and smiles at you at MCDONALD’S. Where do those folks go when they
can no longer care for themselves? They go to the nursing home, their last stop before they become an
entry in a ledger in courthouse file room. They go whether they’re aged 26, 62, or 87. Because there is
nowhere else to go. Because there is NO ONE ELSE to call.

Nursing homes aren’t just for the old and infirm.
Some residents have mental health issues, some
have early dementia, some are just out of options.
Many are there because a friendly NEIGHBOR was
unable to stand as their legal guardian. Maybe their
family lives out of state or they’re disconnected. We
just assume someone will take
care of them. I

mean, it’s AMERICA, right? There are programs for
that. Except there’s really not and it happens all the
time. Most of us don’t even notice.

The more I teach clinical care of our seniors,
particularly those with DEMENTIA, I realize the basis
of what we need to be teaching in our nursing
schools and our elementary schools is one simple
concept. It’s called “HUMANISM.” Somewhere over
the past 200 years we’ve evolved from a village
taking care of its own to leaving them to fend for
themselves. We’re so busy that a huge chunk of
humanity has become somebody else’s PROBLEM.

Humanism is exactly what the word implies.
Treating people as HUMAN BEINGS first and defining
them by their medical condition, age, or abilities
should be second. Often simply making that human
connection is more helpful than a HANDFUL of
PILLS. Humanism is a concept we have to relearn.
It’s taking the time to go beyond the hello at the
check-out line. It’s connecting our kids with people
outside their norm. It’s hugs, TEARS, and laughter.
It’s looking into someone’s eyes and saying, “I care
about you. I have time for you. You’re important to
me.”

Oftentimes the coroner is the last call for these
quiet unknowns but then it’s too late. What will it
take for YOU to stand up and answer?

I WELCOME YOUR COMMENTS AT
WBORENRN@GMAIL.COM.
“Sleep is the golden chain that ties health and our bodies together.” - Thomas Dekker

Sleep is necessary for our bodies to remain healthy. Without proper rest and the deep stages of sleep, we will not feel well and our bodies can’t be at their best. Poor sleep is not a normal part of aging. As we get older, we often get less sleep because our ability to sleep for long periods in deep restful stages can decrease. Our sleep is more fragile and we are more easily disturbed by light, noise and pain. We also may have medical conditions that contribute to sleep problems.

Our bodies heal in deep sleep stages. Starting at the cell level, the cells repair themselves. Muscles, bones and joints heal and grow, and our skin and connective tissue regenerate. If our bodies are not allowed time to renew, how can we fight infections? Deep sleep is also when we decrease our stress and retain what we learned during the day.

The dream stage of sleep is just as important. It helps us with memory recall and also relieves stress. If we don’t get a good night’s rest and fail to dream, we may be more stressed and more easily confused the next day.

How do we get ready for bed? Most of us will brush our teeth, go to the bathroom one more time, and put on different clothes. How do our residents get ready for bed? They may complete the first two tasks, but what do they wear to sleep? Depending on the nursing home, they may wear their own pajamas or a hospital gown several sizes too big.

If our residents are not comfortable in their night clothes, how will they get a good night’s sleep? What else do we do that may disturb their sleep? What about the “turn-every-two-hours, and as-needed” practice? As noted in Sam Plaster’s “Sleep Interruptions” article, that practice is not supported by research and it is not in the Appendix PP Guidelines for Surveyors. Once, restraints were touted as a “good” way to prevent falls, but nursing care has evolved. We now know restraints are harmful and that turning a resident every two hours may not be necessary.

How do we determine when a resident needs to be turned? The research is sparse on this issue. The Centers for Medicare & Medicaid Services’ Guidelines for Surveyors provide a suggestion for homes to determine how long a person can lie in one position before there are signs of tissue injury. The procedure is labor intensive. It requires checking residents for skin redness or tissue injury at 30-minute intervals after they have lain in the same position for more than an hour and documenting the process. However, no published study has determined that procedure’s validity or reliability in predicting pressure ulcer development. The “Comparison Study of Braden Scale and Time-to-Erythema Measures in Long-term Care” supports the use of a valid and reliable risk assessment to develop an individualized care plan to prevent pressure ulcer development. The article was published in the Journal of Wound, Ostomy and

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“The Effectiveness of a Pressure Ulcer Intervention Program on the Prevalence of Hospital Acquired Pressure Ulcers: Controlled Before and After Study,” published in Applied Nursing Research, supports individualized turning schedules based on each individual's particular needs. An interdisciplinary team needs to look at the resident and their overall health and risk assessment to set a baseline of turning. The nursing staff should then observe the resident's skin for redness or tissue injury to see if turning needs to occur more often. If not, the resident should be allowed to sleep at longer intervals undisturbed. The article is available at www.appliednursingresearch.org/article/S0897-1897(14)00112-8/fulltext.

Incontinence may pose another challenge. Some may think, “I can’t allow someone to lie in a wet bed!” or, “Residents must not sleep with incontinence briefs because we need to let their skin breathe.” In fact, historically nursing homes required residents to sleep nude from the waist down to protect them from skin breakdown caused by moisture retention in their incontinence briefs. But we now know that sleeping without undergarments may be demeaning to some. What’s more, incontinence products have improved over the years. They have similar wicking properties as baby diapers, which keep moisture away from the skin. And as parents, we let our babies sleep in diapers; we didn't change those diapers during the night unless our babies woke and cried. Good adult briefs have the capacity to hold adult size amounts of urine and keep the skin dry. Gone are the days of one-size-fits-all adult briefs. Residents respond to individualized care, so they also need individualized incontinence products to meet their specific needs.

Promoting a good night’s sleep will be a challenge for many of us. It means changing old habits and learning new ways to meet a resident’s individual needs.
Scientists seem to agree that we all need seven to eight hours of uninterrupted sleep nightly. Over time, poor sleeping habits have significant negative consequences. The elderly and individuals with dementia are far more likely to suffer from sleep disorders, which make it so important that long-term care environments and care practices are not compounding already significant problems.

I hear about residents’ sleep being interrupted for numerous reasons. Their blood is drawn or vital signs are checked; they have incontinence care, are repositioned, take medications (including sleeping pills), get ready for breakfast; or, they are awakened because of alarms going off, carts being rolled down the hallway, supplies being restocked, shift change, or lights in the hallway. The list goes on and on. Most of these issues are caused by practices based on staff convenience and can be resolved with some simple changes. Others are a bit more complex.

State regulation 19 CSR 30-85.042 (70) currently requires that staff perform position changes every two hours for residents who are physically or mentally incapable of changing their own position. I’ve been told that two-hour repositioning and continence checks are the “accepted standard of practice.”

**Are two-hour repositioning and continence checks really the accepted standard of practice?**

I found that older guidance is more likely to include two-hour repositioning and continence checks as the accepted standard of practice. More recent research and guidance call for a more individualized approach, especially in conjunction with the use of more modern pressure-relieving surfaces and incontinence products.

I started by checking to see what federal surveyor guidance says. The guidance at F314 Pressure Sores, in Appendix PP of the Center for Medicare & Medicaid Services’ State Operations Manual, requires individualized interventions and recognizes that standards of practice are evolving. Resources from the Agency for Healthcare Research and Quality (AHRQ), the National Pressure Ulcer Advisory Panel (NPUAP), the American Medical Directors Association (AMDA), the Quality Improvement Organizations (QIO), the Wound, Ostomy, and Continence Nurses Society (WOCN), and the American Geriatrics Society (AGS) are specifically referenced, so I sought out the latest guidance these organizations have published:

**Agency for Healthcare Research and Quality**

The most recent guidelines found on the AHRQ website, [www.guideline.gov/content.aspx?id=43935#Section420](http://www.guideline.gov/content.aspx?id=43935#Section420), say, “Repositioning schedules should be individualized based on the patient’s condition, care goals, vulnerable skin areas, and type of support surface being used.”

**The National Pressure Ulcer Advisory Panel**

The “2014 Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline” describes an individualized approach to repositioning frequency that includes consideration of pressure redistribution support surface, tissue tolerance, continued on page 12

**The American Medical Directors Association**

The following statements are from the AMDA “Pressure Ulcers in Long-Term Care, Clinical Practice Guidelines”:

- “Evidence does not support any specific time interval for turning patients as a preventative or healing strategy for pressure ulcers.”
- “Repositioning schedules should be individualized according to a patient’s needs, care goals, tissue tolerance, and response to treatment.”
- “Patients at risk of skin breakdown should be placed on a static support surface (e.g., foam overlay, foam mattress, static flotation device) rather than a standard mattress.”

And the following statements are from the AMDA “Sleep Disorders, Clinical Practice Guidelines”:

- “It is recommended that medical directors and managers of long-term care facilities adopt policies and procedures that enhance residents’ ability to obtain a good night’s sleep.”
- “Nighttime incontinence care should be individualized; the goals are to minimize sleep disruption, prevent skin problems in immobile patients, and prevent falls in patients with dementia. For example, implement a policy of ‘checking and changing’ patients after 10 p.m. only if they are awake. Avoid fluid intake (especially of caffeinated beverages) before bedtime and ensuring that patients are toileted before going to bed may help to reduce nighttime awakening due to nocturia.”

These clinical practice guidelines are available for purchase at the AMDA website, [www.amda.com](http://www.amda.com).

**The Quality Improvement Organizations**

The TMF Quality Innovation Network website includes an article entitled, “Less Frequent Turning is Needed with the Right Equipment and Practice, Pressure Ulcer Study Finds.” The article cites recent research that compares repositioning at two-, three-, and four-hour intervals. The incidence of pressure ulcers is the same with all three groups. The article is available at [www.mcknights.com/news/less-frequent-turning-is-needed-with-the-right-equipment-and-practices-pressure-ulcer-study-finds/article/319902/?DCMP=EMC-MCK%20Daily](http://www.mcknights.com/news/less-frequent-turning-is-needed-with-the-right-equipment-and-practices-pressure-ulcer-study-finds/article/319902/?DCMP=EMC-MCK%20Daily).

**The Wound, Ostomy, and Continence Nurses Society**

I found two free webinars on the WOCN website, “Advancing Prevention Through Science: State of the Science in Pressure Ulcer Prevention,” presented by Nancy Bergstrom, Ph.D., RN, FAAN, and “Application of the Science of Pressure Ulcer Prevention in the Clinical Setting,” presented by Elizabeth A. Ayello, Ph.D., RN, ACNS-BC, CWON, MAPWCA, FAAN.

In the first webinar, Dr. Bergstrom discussed the Turning for Ulcer Reduction (TURN) study. The purpose of the TURN study was to determine the efficacy of three repositioning schedules, two-, three-, and four-hours. Dr. Bergstrom said the differences between two-, three-, and four-hour turning were not significant. “When we’re turning people every two hours, particularly at night, we’re awakening them, depriving them of sleep and perhaps decreasing the quality of life and their ability to recover and carry on.”

Dr. Ayello also mentioned the TURN study and said, “We’re beginning to question what is the right time

*continued on page 13*
interval for turning and repositioning.”

The webinars are available at [www.wocn.org/news/news.asp?id=197959&hhSearchTerms=%22pressure+and+ulcer+and+prevention%22].

The American Geriatrics Society

I was unable to find specific guidelines published by the American Geriatrics Society; however the following statement is from the article, “Nighttime Sleep and Bed Mobility among Incontinent Nursing Home Residents,” published in the Journal of the American Geriatrics Society in 1993:

“The majority of incontinent nursing home residents self-initiate sufficiently frequent movements at both the shoulder and hip so as not to be in need of frequent repositioning by nursing staff. Since the sleep of many of these residents is also characterized by frequent awakenings, incontinent nursing home residents may benefit from a schedule of nursing care at night that considers sleep of equal importance to incontinence care and body repositioning.”

An abstract of the article is available at [www.ncbi.nlm.nih.gov/pubmed/8409175].

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<tr>
<th>Excessive tiredness during the day</th>
<th>Decreased alertness</th>
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<td>Memory loss</td>
<td>Disorganized and/or delusional thinking</td>
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<td>Problems with processing things seen and/or heard</td>
<td>Increased irritability</td>
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<td>Disturbed mood and extremes of manic behavior</td>
<td>Loss of emotional control e.g. anger management</td>
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<td>Increased behavioral expressions of discomfort</td>
<td>Loss of social appropriateness</td>
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In 2014, I sat in on a webinar on the Empira Fall Study. Empira is a collaboration of nursing homes in Minnesota involved in gerontological research, funded through the Minnesota Department of Human Services’ Performance-Based Incentive Payment Program.

Sixteen skilled nursing homes participated in a three-year investigation to identify the root causes of resident falls. During the project, the prevalence of falls was reduced by 31% through interventions that included noise reduction and alarm elimination.

Sleep disturbance was also identified as a primary factor that contributed to falls. However, it was determined that additional research was necessary. Funding was obtained and a second, three-year project was initiated, but we would have to wait for results.

The original webinar is still available through the Pioneer Network at [www.pioneernetwork.net/Events/OnDemand/].

I recently had the opportunity to attend the 2015 Pioneer Network conference in Chicago. Empira team members Sarah Brown, RN, BS, LNHA; Sue Ann Guildermann, RN, BA, MA; and Cindy Morris, BS, MBA, LNHA, led an all-day intensive training session entitled, “Restorative Sleep Vitality Program,” and shared the results of the second, three-year study.

I will share some points that I believe warrant serious consideration.

During the three-year project, Empira representatives gained exhaustive knowledge of sleep hygiene from existing evidence-based research. They also attended national and international sleep conferences and conventions. They learned that adult humans need an average of seven to eight hours of “uninterrupted” sleep nightly. Elders require an average of eight hours.

Ms. Guildermann shared that military-professional presenters at an continued on page 14
international sleep conference said sleep fragmentation is the most effective method for breaking down enemies physically and psychologically. Two-hour disruptions are the most effective intervals.

Sleep occurs in cycles and each stage provides distinct physiological and emotional benefits. Those cycles aren’t attained and the benefits aren’t realized when sleep is fragmented by even slight interruptions. Individuals subjected to sleep fragmentation over long periods of time suffer significant harm. Symptoms of sleep fragmentation include:

Guildermann pointed out that these symptoms are nearly identical to those of psychosis and questioned whether antipsychotics are sometimes being used to treat incorrectly diagnosed symptoms of psychosis that are actually brought on by sleep fragmentation.

During the Empira study, many interventions were put into place to reduce sleep interruptions, including the use of pressure relieving mattresses, improved incontinence products, and barrier ointment/creams. Instances of incontinence were reduced through fluid monitoring and management. Residents were encouraged to drink lots of fluids in the mornings, but to taper fluid intake after lunch, and minimized as much as possible after dinner. Medication administration schedules were altered to minimize the need for additional fluids for evening medications. In instances when evening medications were necessary, liquid medications were used because fluid intake is less than what is necessary to take pills.

Residents wore wrist actigraphy devices to monitor movement. The devices suggest that many residents reposition themselves while sleeping, eliminating the need for staff to reposition them.

Skin condition assessments were conducted, allowing for longer and longer periods of not being repositioned, changing incontinence products, or toileting. Through these interventions and many more, the percentage of residents who were to receive two-hour checks and/or repositioning was reduced from 99 percent to 7 percent. Reducing interruptions resulted in no negative outcomes.

The two-hour repositioning frequency required by 19 CSR 30-85.042 (70) will be considered for revision when the regulation is open for review. In the meantime, surveyors expect person-directed, individualized care, and evidence-based approaches to assessment, care planning, and care delivery.

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**SAVE THE DATE**

Presented by MOLANE, MC5, and MHCA...

Empira researcher Sue Ann Guildermann will be providing three half-day presentations on the harm created from interrupted sleep and strategies for providing a good night’s sleep for LTC residents.

**NOVEMBER 29: ST. LOUIS | NOVEMBER 30: LAKE OZARK | DECEMBER 1: KANSAS CITY**

MORE DETAILS TO FOLLOW
Antipsychotic Reduction | Resident Prioritization Tool Part 1*

The actions in the pink hexagons are intended to be addressed before moving to Part 2.

**Box 1**

MDS-Referenced Diagnosis
- Schizophrenia
- Schizoaffective disorder
- Tourette syndrome
- Huntington disease

*Consult MDS for more information.*

**Box 2**

Common Low or Starting Dose
- Quetiapine (Seroquel) 12.5-25mg
- Olanzapine (Zyprexa) 2.5-5mg
- Risperidone (Risperdal) 0.25-0.5mg
- Aripiprazole (Abilify) 2-5mg
- Ziprasidone (Geodon) 20-40mg

*This material was prepared by Health Services Advisory Group, the Medicare Quality Improvement Organization for Arizona, California, Florida, Ohio, and the U.S. Virgin Island, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, from material originally prepared by Telligen, under contract with CMS. The contents presented do not necessarily reflect CMS policy. Publication No. QN-115OW-C.2-01152016-01*
Antipsychotic Reduction | Resident Prioritization Tool Part 2*

- This flowchart was developed in part utilizing documentation with permission from Dr. Thomas Magnuson of the University of Nebraska Medical Center published article “Reductions in Antipsychotics in Long Term Care”

- Always consult the provider
  - Dose reductions should be approached with awareness and caution for symptoms of withdrawal
  - Documentation is key for target symptom management and outcomes tracking

Use this ONLY to evaluate residents after completing Part 1 (other side)

List Residents      Target Symptom
____________________  __________________
____________________  __________________
____________________  __________________
____________________  __________________
____________________  __________________
____________________  __________________
____________________  __________________
____________________  __________________

Non-Aggressive Target Symptom Absent

Target Symptom absent for less than three months**

Aggressive Target Symptom*
  Behavior that causes physical or emotional harm to others or one’s self, or threatens to.

Non-Aggressive Target Symptom Persists**
  Hallucinations, delusions (do not mistake delusions for memory problems)

Target Symptoms Where Antipsychotic Treatment May Be Inappropriate
  Wandering, not being social or friendly, poor self-care, restlessness, uncooperativeness without aggression. Consult provider.

Add up points for each resident in the green boxes above (#1 is 1 point etc.)
Resident_______ Points_____
Resident_______ Points_____
Resident_______ Points_____
Resident_______ Points_____

The resident with the LOWEST point total should be considered first for dose reduction.

RANK

Rank residents in order of who has been symptom-free the longest (longest is #1)
1____________________
2____________________
3____________________
4____________________

Time it took to become free of target symptom (shortest time is #1)
1____________________
2____________________
3____________________
4____________________

How long resident has been on medication (longest time is #1)
1____________________
2____________________
3____________________
4____________________

Dose of medication (highest dose is #1)
1____________________
2____________________
3____________________
4____________________

FREE of non-aggressive target symptom
Non-Aggressive Target Symptom Absent

These lists are not comprehensive and are intended to be used only as guidance.

*In aggressive residents, six months of stability may be needed.
**In non-aggressive residents, three months of stability is reasonable before a reduction is attempted.