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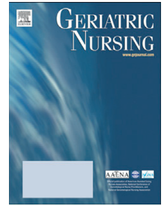

Assisted Living Column

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Learning from lumberjacks to reduce calls and improve care

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So the story goes that a lumberjack is getting exhausted cutting down a tree when someone taps on his shoulder and asks why don't you take some time to sharpen your axe so you can more effectively cut down that tree – the lumberjack says I'd love to but I don't have time for that.

How many times has this happened where providers feel they are so busy that they can't take time out to improve the process. This is especially true when it comes to afterhours LTC calls – all too often providers feel they are too busy to take time out to develop an efficient and effective plan to better manage these calls. Even worse, they may try to fix the problem on the spot during the phone call where they feel they are not getting adequate information. Often this results in an unpleasant encounter that does not get us to the goal of improving future interactions. In fact, just the opposite happens where staff will often voice that they feel intimidated in reaching out to that practitioner the next time one of their residents has a problem.

Put another way – Give me six hours to chop down a tree and I will spend the first four sharpening the axe. Abraham Lincoln – basically again rather than just complain about being hassled by after hour LTC calls perhaps it's time to develop a system to more appropriately manage them.

The starting point is first determining where the gaps in management processes exist. By assessing each and every call that occurs for the reason for that call and determination of whether that call is really necessary at all or if a different time would be more appropriate. Further, determination of a protocol that could be put in place to better manage the care in these situations. While this proactive sharpening of the blade will help future calls, clinicians must be in a position to appropriately manage the calls that they get. This management requires much more thoughtfulness today than simply directing LTC staff to send the patient to the hospital.

	PROACTIVE MANAGEMENT What protocols, plan, education can be used for more effective future management?
Pain management	Pain management requires appropriate assessment followed by an efficient and effective process for accessing what is needed to get the pain under control as quickly an as safely as possible. This process can include educating hospitals to discharge patients to LTCs with actual prescriptions for pain medications that can be provided to the LTC Institutional Pharmacy Provider to avoid access delay, if your facility policy allows. If not, you will have to first explore the possibility of changes policies as your local regulatory agencies allow. When LTC attending providers are required to gain access there needs to be a process for these attendings either sending a hard prescription, eScript of a controlled medication or provide verbal authorization.
CII refill	Working with the pharmacy to assure that prior to CIIs needing to be refilled that this is accomplished during the work week business hours. Much of this process will also rely on effective monitoring by the nursing staff to alert the pharmacy regarding the need for refills as their current supply is running out.

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INR Results	Have both a set protocol for Coumadin/Warfarin dose adjustment based on PT/INR including time of day to provide results, avoiding after hours calls. A set protocol for dose adjustment. Also complete PT/INR via point of care monitor so results are available during the work day rather than early evenings. Guidance on the management of warfarin can be found in the AMDA anticoagulation clinical practice guidelines as well as the American College of Chest Physician's Evidence-Based Clinical Practice Guidelines. As you formulate protocols for Coumadin/Warfarin dose adjustment, remember to recognize the aspects of increased surveillance that is necessary when this medication is used in combination with episodes of antibiotic therapy. In addition, LTCs can also identify patients better managed on novel oral anticoagulants (NOACs) that do not require frequent INR monitoring. One aspect to consider in identifying patients who may be better managed on novel oral anticoagulants is there baseline renal function. Most resident's in long-term care facilities have levels of renal function that would safely permit the use of these agents.
UA results	Protocol in place to assure that UAs are only done in face of true UTI concern and that antibiotic use when appropriate is based on regional sensitivity studies; thus limited development of resistant organisms. As facilities develop antimicrobial stewardship programs they should focus on obtaining antibiograms to assist them in choosing appropriate empiric antibiotic therapy when indicated. Remember that for antibiograms to be effective in helping you understand the sensitivities of organisms in the region there must be a significant occurrence of pathogens. Generally, it is thought that a pathogen must appear a minimum of 35 times on a report in order for you to make valid conclusions about its sensitivity patterns to common antibiotics that you may choose to use against it. In order to gain sufficient numbers you may need to request that your laboratory produce reports that cover significant periods of time. Reports that are generated should cover a minimum of 1 year and in some cases, where specimen numbers are smaller, you may need to have reports that cover up to 2 years.
Abnormal labs	Protocols that dictate when abnormal labs are to be called to attending physician after hours. Ideal is labs are available during the day when a facility based APN can respond in a timely manner. In addition, certain reported laboratory abnormalities may be more appropriately managed after the patient has been physically assessed. Once again, this is best accomplished when laboratory results can be available when practitioners, including APN's, are in the building and available to physically assess the residents. In addition, review your laboratory policies that address the immediate notification by the laboratory for "panic" values. Your policy should clearly state, for each laboratory result, what your panic threshold is for when the laboratories should immediately notify the facility by telephone of a result so that prompt action can be taken.
Fall	Fall prevention which include assessment, implementation of a plan, and assessment post fall. Immediate post fall evaluation that may include careful assessment with a head CT for patients with noted head trauma on anticoagulants. Facilities often fall into the trap of immediately calling to report a fall with no injury then failing to have any follow-up discussion when the prescriber is in the facility to make rounds. When this happens, opportunities are lost to examine the patient for subtle details that may be implicated in the falls. This can be especially detrimental in patients who have repeated falls without injury where there is failure to sit down and look at the general picture to find several issues that may be manageable.
Agitated behavior	Staff training to be prepared to successfully manage acute agitation, ideally with non-pharmaceutical approaches.
New wound	Process for not only notification to attending of a new wound but how appropriate management will occur so that wounds can treated and monitored in such a way to promote healing. Part of this requires notification of family so that expectations can be managed.
ED/Hospital	Calls on change of status where ED/Hospital are considered should follow adaption of INTERACT, AMDA Guideline for Change in Condition, or similar pathway. Communication of this information should be in the format of SBAR: Situation, Background, Assessment and Recommendation. All transfers to acute care settings, whether they result in hospitalization or not, should be reviewed regularly and data should be organized in such a way that areas in need of clinical improvement can be identified so that targeted staff training and education can take place.
Outside of appropriate range (temperature, BP, HR, Blood Sugar)	Situations of temperature, BP, HR, and blood sugar can be typically managed through standing orders with situations outside of the range called to attending physician with appropriate information on vitals, clinical situation and relevant history.
Consult Recommendations	Consultant recommendations should be triaged such that routine recommendations are held until the working day. Emergent recommendations need to be communicated as soon as possible.
Availability of Medications and Missed doses	When medications are not available the prescriber should be notified immediately so that they can give instructions for an alternate plan until the medications are available. When doses are missed due to patient refusal, the prescriber should also be notified as soon as possible with information as to why the patient has refused the dose. Perhaps the patient feels that the medication isn't working or is bothered by an adverse medication event that has not been discovered a reported. In either event, the prescriber needs to be notified so that additional investigation can take place.

Protocols

One does not have to reinvent the wheel when it comes to protocols for management of LTC issues in an effort to improve outcomes including reduce calls. LTC providers will be well served to start from existing protocols such as those available through AMDA. AMDA's clinical practice guidelines (CPGs) have become the standard care process in the post-acute and long-term care (PA/LTC) setting.

AMDA CPGs are positioned to reduce: costs, avoidable transfers, and risk of survey penalty and litigation. Most importantly, AMDA CPGs can improve: patient outcomes, and safety of staff, facility, and patients.

AMDA CPGs emphasize key care processes and are organized for ready incorporation into facility-specific policies and procedures to guide staff and practitioner practices and performance, although LTC organizations are best served when they use these guidelines as a starting point from which they can develop their own.

The AMDA CPG implementation recommendations follows the medical care process of recognition, assessment (root cause analysis), treatment (based on assessment), and monitoring. Again these steps can be built with specifics for each LTC organization. Once guidelines have been developed and implemented they must be constantly reinforced with the staff with scheduling of frequent teaching sessions to ensure that new staff gain quick familiarity with the system. With the rapid turnover that most facilities are faced with, it is crucial to constantly review and teach clinical policies.

Beyond the AMDA CPG, LTC organizations can also use other guidelines as to build their own system. One of these other resources is INTERACT® (Interventions to Reduce Acute Care Transfers). INTERACT is a quality improvement program that focuses on the management of acute change in resident condition. It includes clinical and educational tools and strategies for use in every day practice in long-term care facilities. By using the AMDA CPG and/or INTERACT a LTC organization can develop specific guidelines

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