"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
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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

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.
**DIRECTOR OF NURSING**

**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
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

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.
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

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

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...
### 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.

### 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.
**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
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.”

- 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*)

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.

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**Monthly Medical Director Report**

**Date** | **Involved Parties** | **Discussion** | **Time**
---|---|---|---
April 1, 2017 | Shari, Paula | Monday afternoon phone call. Review data of facility. Discussed letter to employees threatening fine if the facility does not reduce influenza rates. Board meeting regarding report. | 30 min
April 2, 2017 | Daily | Daily review of facility's performance. | 10 min
April 4, 2017 | Total, Paula, Shari | Companded and shared with employees. | 15 min
April 4, 2017 | Total, Paula, Shari | Shared and discussed with residents of need for ongoing assessment. | 15 min
April 11, 2017 | Paula | Set up monthly call for April 11. | 30 min

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**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

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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...”
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 your 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

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**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:
  o Develop/implement/evaluate/revise procedures for provision of pharmaceutical services
  o Coordination of pharmaceutical services if and when multiple providers are used (i.e. hospice, IV pharmacy, PDP)
  o 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 reduced 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
  o 483.45(b) Service Consultation
  o 483.45(g) Labeling of Drugs & Biologics
  o 483.45(h) Storage of Drugs & Biologics

F-Tags continued:

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

F-Tags continued:

• F428 – 483.45(c) Drug Regimen Review
  o 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
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)
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

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

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, amlopidine, ASA, buspirone, Vitamin D, sertraline, Vitamin B12, analgesic balm, terazosin (newly initiated in hospital)
Wisconsin Healthcare‐Associated Infections in LTC Coalition

**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 >500 mL straight cath, continue bladder scan if no void and replace primary catheter.

**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.”

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**Questions/Discussion**

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**Bibliography**

“The Nursing Home Medical Director: Leader and Manager” (White Paper A-11) AMDA web-site
http://www.paltc.org/amda-white-papers-and-resolution-position-statements/nursing-home-medical-director-leader-manager

“Revised Interpretive Guidelines for Tag F501, Medical Director” S& C-05-29, CMD/DHHS. June 9, 2009
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<td>• State Operations Manual (SOM) Appendix PP – CMS</td>
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