Welcome to Telligen's Project ECHO® Series: Long-Term Care Medication Management of Blood Thinners

We will get started momentarily

- Using chat, enter your organization and state
- Please complete the poll

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Project ECHO®

A Project ECHO® Series: Long-Term Care Medication Management of Blood Thinners

Session 4 – Communication with prescribers, pharmacists and others outside the facility

Wednesday, August 23, 2023

Carolyn Dutton, RN, LNHA, Sr. Quality Improvement Facilitator
Panelists: Dr. Gregory Gahm, Dr. Keith Swanson & Dr. Bryan Whyms

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- Project ECHO® collects registration, participation, questions/answers, chat comments and poll responses for some ECHO® programs. Your individual data will be kept confidential. These data may be used for reports, maps, communications, surveys, quality assurance, evaluation, research and to inform new initiatives.

Before We Begin

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  - If you unsubscribe, you'll miss out on every communication we share
- We're on social media, follow us for updates and events!

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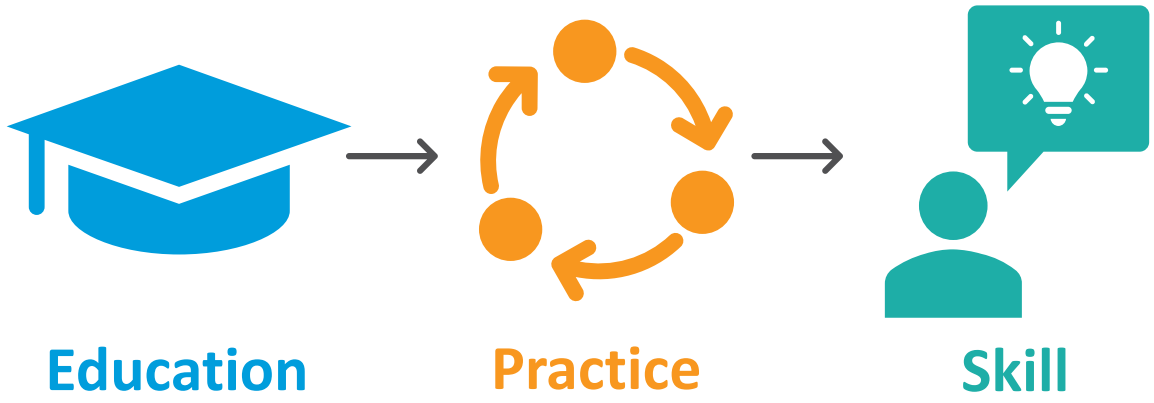
- NEW! Telligen's nursing home listserv – sign up HERE

Begin With the End in Mind

- During the presentation, visualize and plan how you will use the information:
  - What impactful actions can you take as a result of the information shared today?
  - How are you able to increase collaboration within your network to ensure a true change in patient safety?
  - Based on what you heard today, what activities do you currently have underway that can leverage immediate action over the next week, 30, 60 and 90 days?



Objectives

- Describe the importance of collaboration with prescribers and pharmacist when administering anticoagulants
- Identify key information necessary to ensure best resident outcomes when communicating with prescribers and pharmacist
- Present options for implementing best practices when collaborating across the care continuum

Communication

Webster's Dictionary defines communication as "the imparting or interchange of thoughts, opinions, or information by speech, writing, or signs." It is important to consider that communication is not just verbal in form. However, critical information is often transmitted via handwritten notes, e-mails, or text messages, which can lead to serious consequences if there is miscommunication.

https://www.ncbi.nlm.nih.gov/books/NBK2637/

Collaboration

Collaboration in healthcare is defined as healthcare professionals assuming complementary roles and cooperatively working together, sharing responsibility for problem-solving and making decisions to formulate and carry out plans for patient care. Collaboration between physicians, nurses, and other healthcare professionals increases team members' awareness of each others' type of knowledge and skills, leading to continued improvement in decision making.

https://www.ncbi.nlm.nih.gov/books/NBK2637/

Collaboration Across the Care Settings

- When healthcare professionals are not communicating effectively, patient safety is at risk for several reasons:
  - Lack of critical information
  - Misinterpretation of information
  - Unclear orders over the telephone
  - Overlooked changes in status
- Lack of communication creates situations where medical errors can occur
  - These errors have the potential to cause severe injury or unexpected patient death

https://www.ncbi.nlm.nih.gov/books/NBK2637/

Gregory Gahm, MD
Chief Medical Officer
Vivage Beecan Colorado

- A realistic understanding about why we anticoagulate anyone that can be shared with residents/families along with a recommendation to follow-up with their provider(s) for more details
- The importance of understanding the basics of anticoagulation so that you can advocate for residents
- Anticoagulation is a dangerous undertaking (i.e., giving medications intended to allow your residents to bleed)
    - When you suspect something is wrong, question it!

"Nurses/staff should not be afraid to confront or question providers/specialists when something doesn't look right. Waiting until after they've had a major GI bleed, hemorrhagic stroke, DVT, PE or CVA is too late to wonder what could have been."

Brian Whyms, DO
Regional Director
Curana Health in IA, MN, WI

- Inform the physician the past 1-2 months of INR results for patients on warfarin. Recommend the patient may be better served with a DOAC (direct oral anticoagulant)
- Remind the physician how many times the patient has been on an antibiotic in the last 3-6 months. Many antibiotics and acute infections can really affect a patient's INR. Advise the physician to support resident safety the patient would benefit from a safer blood thinner
- Coordinate a call between the physician and the pharmacist when your system flags and alerts you of patients on warfarin. Ask your pharmacist to use their expertise in medications to inform the physician

Dr. Keith A. Swanson, Pharm.D.
Associate Professor of Pharmacy Practice
University of Oklahoma College of Pharmacy

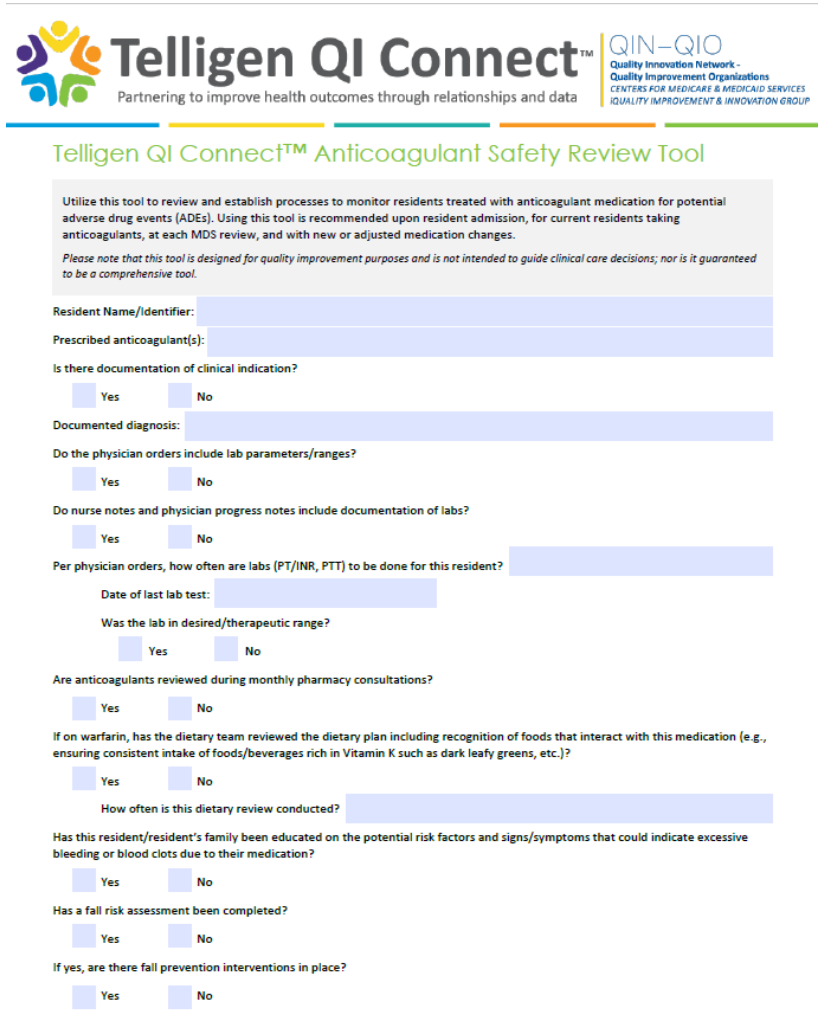
Optimizing pharmacy communications in LTC settings:

- Build and then nurture the relationship
- Keep goal in mind – patient care and safety always comes first
- Respect others' perspectives and don't apologize for doing your job
- Don't let emotions overshadow the message
- Recognize limitations and barriers of digital methods of communication

Case Study: Let's Discuss

Lucy is 84-year-old resident who was admitted to the facility 6 months ago with a diagnosis of Alzheimer's Disease. Lucy fell last month and sustained a left hip fracture and required surgical intervention. She was readmitted three weeks ago with an order for Coumadin 2mg daily and an order for a PT/INR in 2 weeks. She was also prescribed Ferrous Sulfate 325mg TID due to anemia following her hip surgery. The nurse who readmitted Lucy, notified the pharmacy of the new medication orders and the lab of the order for the PT/INR. A week after her readmission to the facility, Lucy was diagnosed with a UTI and was prescribed Septra DS. Three days later, during her morning care, Lucy complained of stomach cramps and was noted to have dark stools. The C.N.A. also noted some blood on the Lucy's toothbrush. She reported all these things to the nurse. The nurse checked Lucy's chart and noted that she was receiving Ferrous Sulfate. She also noted that she was recently prescribed Septra DS which she knew can have a side effect of stomach upset. After therapy that day, the therapist reported that she hasn't been herself and has had difficulty completing her therapy the past 3 days. She couldn't complete her therapy this day because she was too tired and short of breath. The following day, Lucy appeared pale and weak. An assessment revealed she had a rapid pulse and her blood pressure was lower than usual. Lucy was transferred to the emergency room for evaluation and was admitted to the hospital with a GI Bleed.

Telligen QI Connect™ Anticoagulant Safety Review Tool



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Telligen QI Connect™ Anticoagulant Safety Review Tool

Utilize this tool to review and establish processes to monitor residents treated with anticoagulant medication for potential adverse drug events (ADEs). Using this tool is recommended upon resident admission, for current residents taking anticoagulants, at each MDS review, and with new or adjusted medication changes.

Please note that this tool is designed for quality improvement purposes and is not intended to guide clinical care decisions; nor is it guaranteed to be a comprehensive tool.

Resident Name/Identifier:

Prescribed anticoagulant(s):

Is there documentation of clinical indication?

☐ Yes ☐ No

Documented diagnosis:

Do the physician orders include lab parameters/ranges?

☐ Yes ☐ No

Do nurse notes and physician progress notes include documentation of labs?

☐ Yes ☐ No

Per physician orders, how often are labs (PT/INR, PTT) to be done for this resident?

Date of last lab test:

Was the lab in desired/therapeutic range?

☐ Yes ☐ No

Are anticoagulants reviewed during monthly pharmacy consultations?

☐ Yes ☐ No

If on warfarin, has the dietary team reviewed the dietary plan including recognition of foods that interact with this medication (e.g., ensuring consistent intake of foods/beverages rich in Vitamin K such as dark leafy greens, etc.)?

☐ Yes ☐ No

How often is this dietary review conducted?

Has this resident/resident's family been educated on the potential risk factors and signs/symptoms that could indicate excessive bleeding or blood clots due to their medication?

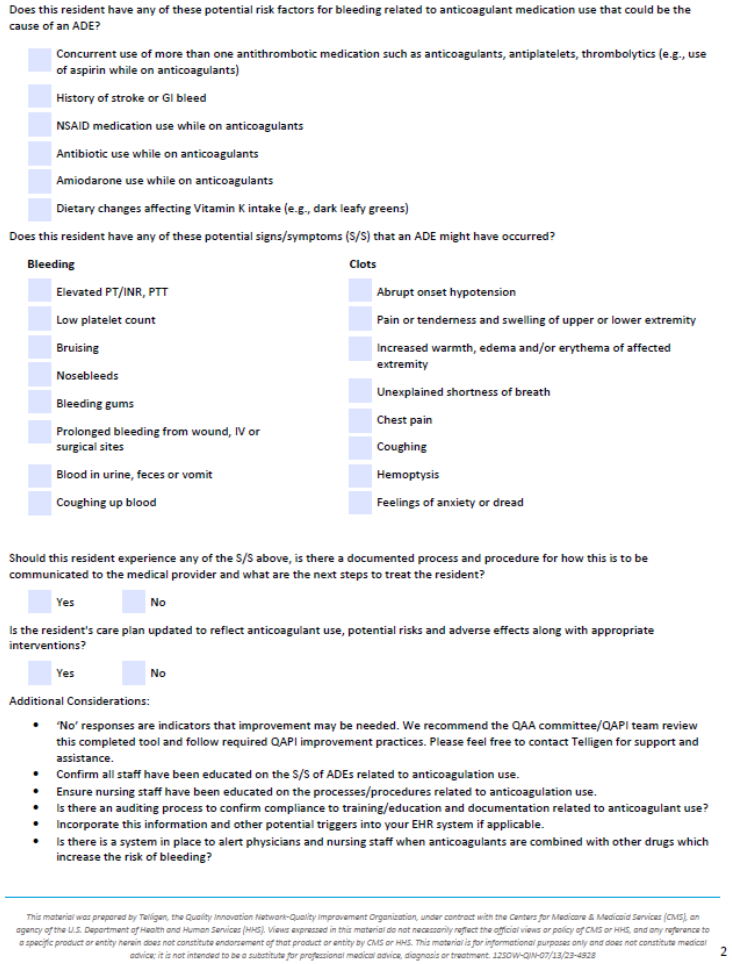
☐ Yes ☐ No

Has a fall risk assessment been completed?

☐ Yes ☐ No

If yes, are there fall prevention interventions in place?

☐ Yes ☐ No



Does this resident have any of these potential risk factors for bleeding related to anticoagulant medication use that could be the cause of an ADE?

- ☐ Concurrent use of more than one antithrombotic medication such as anticoagulants, antiplatelets, thrombolytics (e.g., use of aspirin while on anticoagulants)
- ☐ History of stroke or GI bleed
- ☐ NSAID medication use while on anticoagulants
- ☐ Antibiotic use while on anticoagulants
- ☐ Amiodarone use while on anticoagulants
- ☐ Dietary changes affecting Vitamin K intake (e.g., dark leafy greens)

Does this resident have any of these potential signs/symptoms (S/S) that an ADE might have occurred?

Bleeding

- ☐ Elevated PT/INR, PTT
- ☐ Low platelet count
- ☐ Bruising
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Prolonged bleeding from wound, IV or surgical sites
- ☐ Blood in urine, feces or vomit
- ☐ Coughing up blood

Clots

- ☐ Abrupt onset hypotension
- ☐ Pain or tenderness and swelling of upper or lower extremity
- ☐ Increased warmth, edema and/or erythema of affected extremity
- ☐ Unexplained shortness of breath
- ☐ Chest pain
- ☐ Coughing
- ☐ Hemoptysis
- ☐ Feelings of anxiety or dread

Should this resident experience any of the S/S above, is there a documented process and procedure for how this is to be communicated to the medical provider and what are the next steps to treat the resident?

☐ Yes ☐ No

Is the resident's care plan updated to reflect anticoagulant use, potential risks and adverse effects along with appropriate interventions?

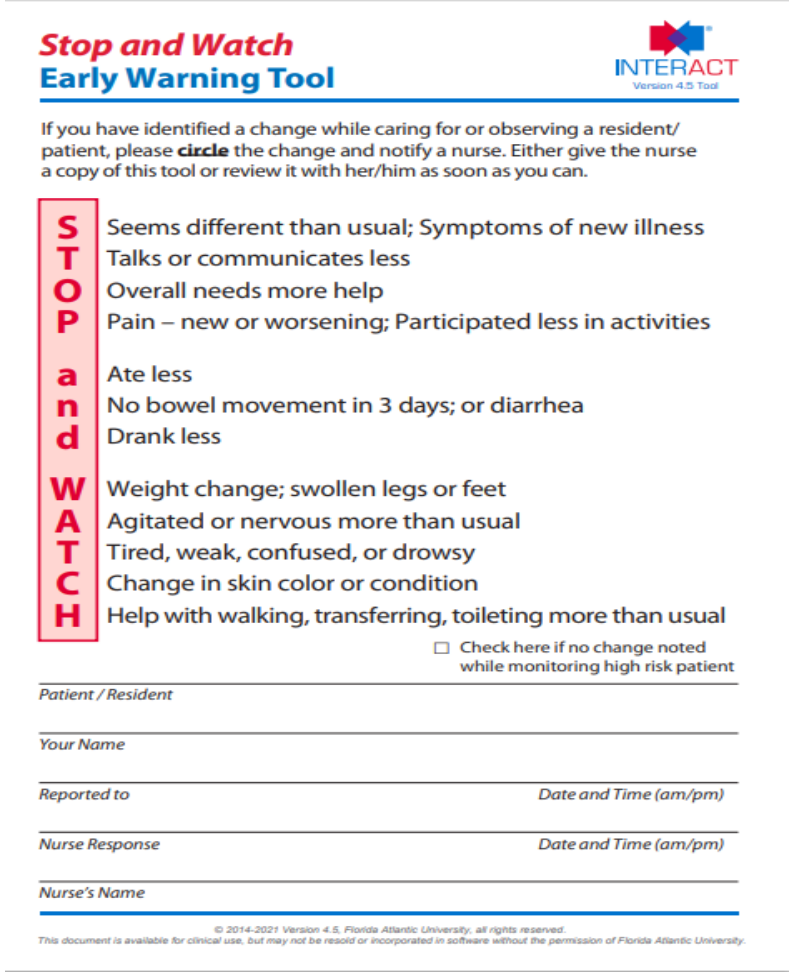
☐ Yes ☐ No

Additional Considerations:

- 'No' responses are indicators that improvement may be needed. We recommend the QAA committee/QAPI team review this completed tool and follow required QAPI improvement practices. Please feel free to contact Telligen for support and assistance.
- Confirm all staff have been educated on the S/S of ADEs related to anticoagulation use.
- Ensure nursing staff have been educated on the processes/procedures related to anticoagulation use.
- Is there an auditing process to confirm compliance to training/education and documentation related to anticoagulant use?
- Incorporate this information and other potential triggers into your EHR system if applicable.
- Is there is a system in place to alert physicians and nursing staff when anticoagulants are combined with other drugs which increase the risk of bleeding?

https://www.telligenqiconnect.com/resource/anticoagulant-safety-review-tool/

Stop and Watch Early Warning Tool



Stop and Watch
Early Warning Tool

INTERACT
Version 4.5 Tool

If you have identified a change while caring for or observing a resident/ patient, please **circle** the change and notify a nurse. Either give the nurse a copy of this tool or review it with her/him as soon as you can.

S	Seems different than usual; Symptoms of new illness
T	Talks or communicates less
O	Overall needs more help
P	Pain – new or worsening; Participated less in activities
a	Ate less
n	No bowel movement in 3 days; or diarrhea
d	Drank less
W	Weight change; swollen legs or feet
A	Agitated or nervous more than usual
T	Tired, weak, confused, or drowsy
C	Change in skin color or condition
H	Help with walking, transferring, toileting more than usual

☐ Check here if no change noted while monitoring high risk patient

Patient / Resident

Your Name

Reported to *Date and Time (am/pm)*

Nurse Response *Date and Time (am/pm)*

Nurse's Name

https://pathway-interact.com/interact-tools/interact-tools-library/

Foundational Components

Appendix B

- Develop an infrastructure that promotes teamwork and communication
- Establish a consistent admissions process to prevent errors, omissions and gaps in care
  - Assign consistent staff to care areas
  - Identify consistent communication processes
  - Review concerns with leadership teams
  - Share care plans
  - Establish expectations to use communication tools and resources
    - Consider visual cues to support safety
  - Recognize staff for supporting the vision

2018 All Cause Harm Prevention in Nursing Homes Change Package

Overview recording

Next Steps – Lead into Action

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High-Risk Medication ECHO® Series Resources

Seven sessions to share key information and strategies focusing on medication management, resident safety and quality of care

- Review each session's summary at the website and prioritize improvement needs
- Watch each session recording
- Use the tools and resources
- Implement the call to action under each session title

https://www.telligenqiconnect.com/high-risk-medication-echo-series/

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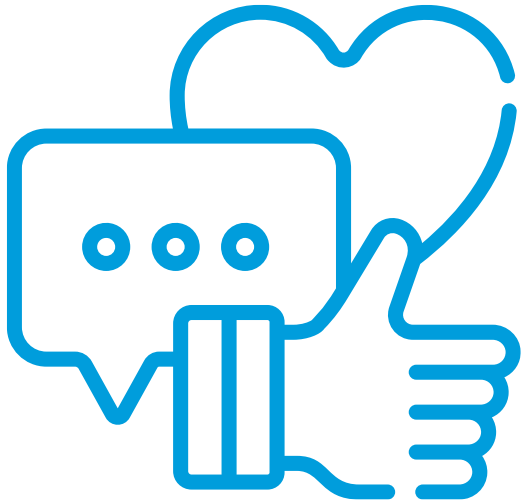
How Did We Do? Let Us Know:



Please fill out the poll before logging off

Project ECHO® Series for **Long-Term Care** Medication Management of Blood Thinners

Share your mission to improve blood thinner medication management with those in your network.

Access session presentations and recordings here!

ECHO® Session Topics:

- Session 1: Introduction to adverse drug events related to anticoagulants
- Session 2: Anticoagulant adverse drug event recognition and Safety Review Tool
- Session 3: Communication with residents and representatives
- Session 4: Communication with prescribers, pharmacists and others outside the facility

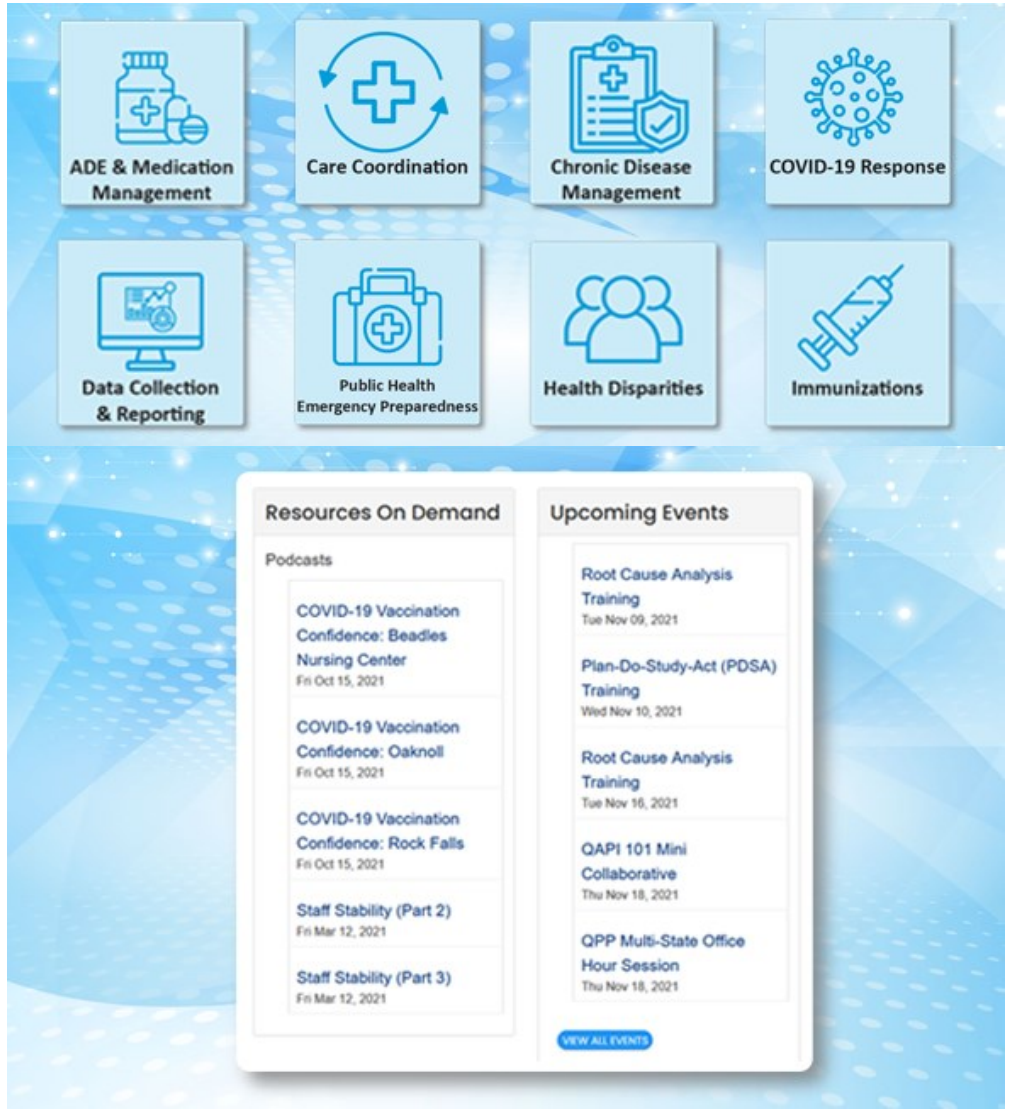
Project ECHO® Series on Anticoagulant Best Practices for **Prescribers and Pharmacists**

Share your mission to improve anticoagulant medication management with your supporting services.

Access session presentations and recordings here!

ECHO® Session Topics:

- Session 1: Introduction to anticoagulant adverse drug events and the impact on long-term care
- Session 2: Warfarin prescribing practices
- Session 3: Uses for Direct Oral Anticoagulants (DOACs)



Secure Portal

The Telligen QI Connect™ Secure Portal provides users exclusive access to events, tools, resources and data reports to support your healthcare quality improvement work with Telligen.

The online network offers an opportunity to share and learn about innovative practices, all at no cost.

Access the Portal

Need Portal Help?

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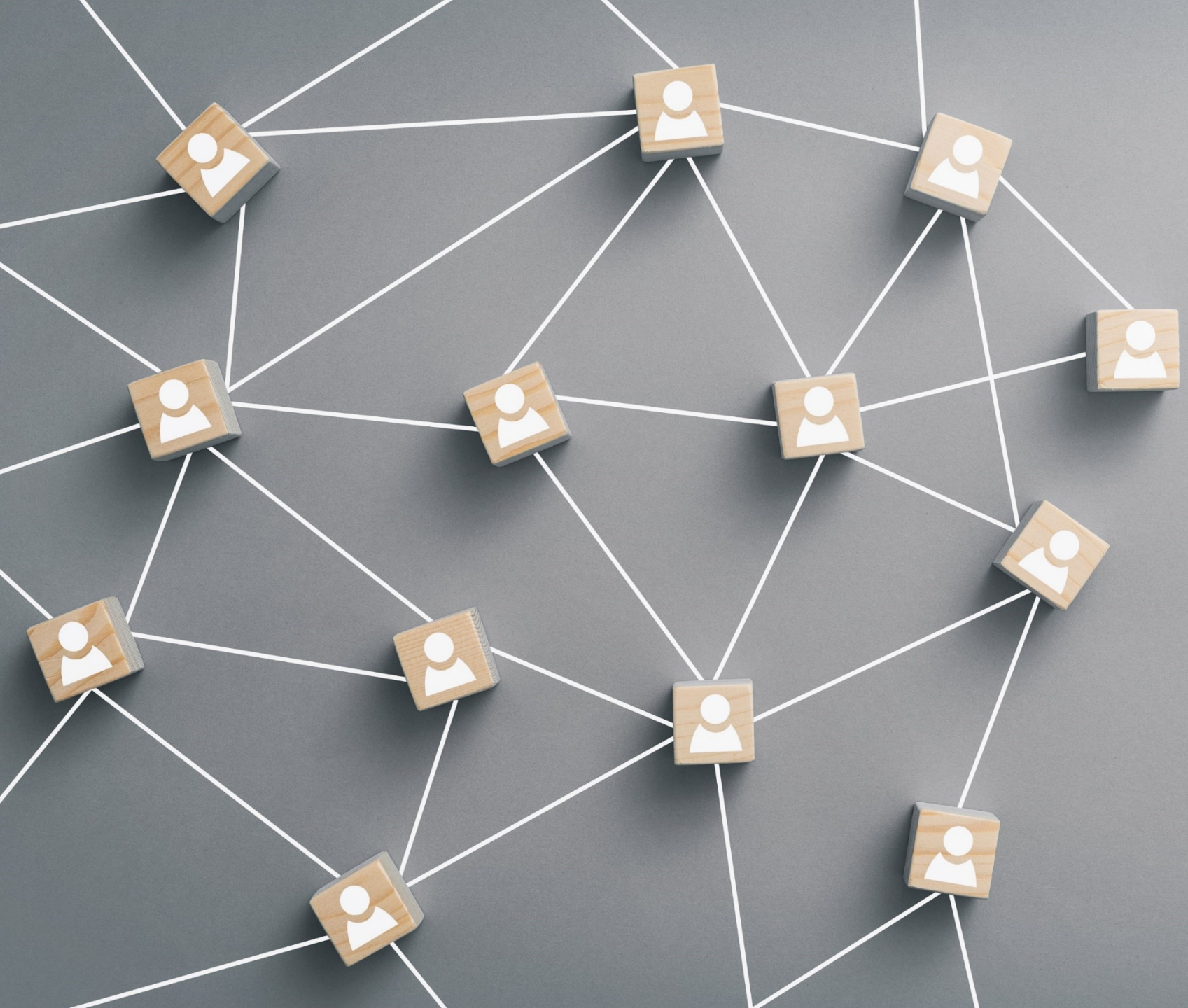
Contact Us

- Nursing Home Team nursinghome@telligen.com
- General Inquiries | QIConnect@telligen.com
- www.telligenqiconnect.com



Let’s Talk –
Stay an extra
15 minutes to
network