Interprofessional Team Management of COVID 19 In Nursing Homes

Cohort 7 Session 11

February 12, 2021

9:30 am

AHRQ ECHO National Nursing Home COVID-19 Action Network

UNM HEALTH SCIENCES | Project ECHO | AHRQ Agency for Healthcare Research and Quality | Institute for Healthcare Improvement | Massachusetts Senior Care Association | Hebrew SeniorLife | Harvard Medical School Affiliate

Today's Agenda

Follow-up

Interprofessional Team Management of COVID 19 in Nursing Homes

Monoclonal Antibody Treatment Video

Performance Improvement Discussion

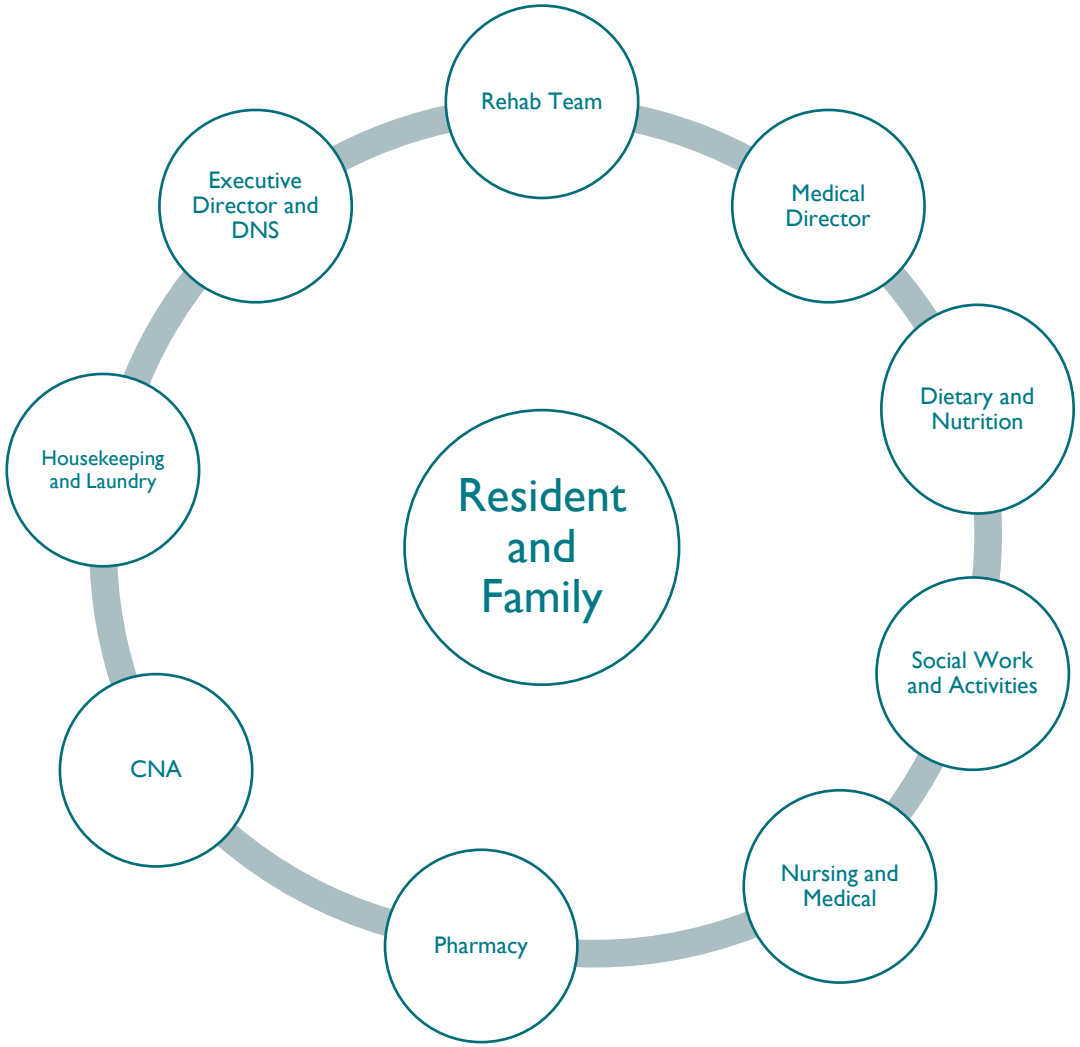
Wrap-up and Poll

Questions & Answers

Vaccine Clinic Follow Up

Interprofessional Team Management of COVID 19 In Nursing Homes

The Interprofessional Team



EXAMPLES:

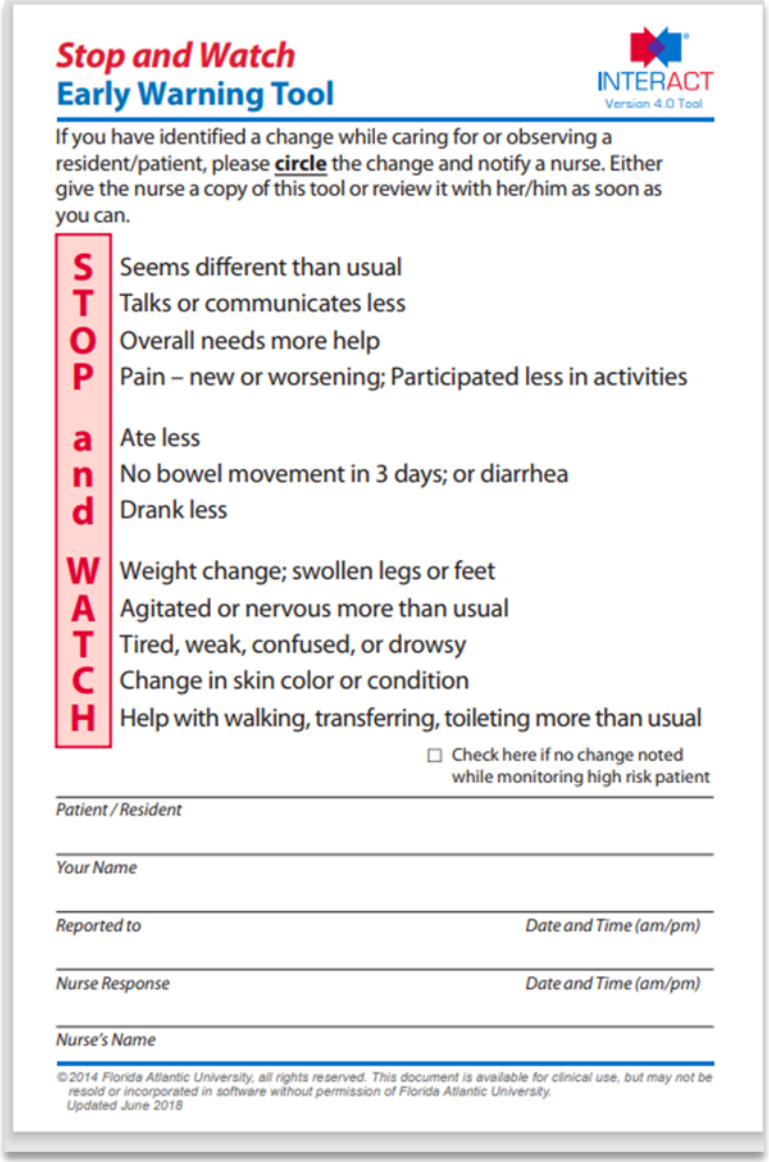
- Rehab Team-_____
- Dietary and Nutrition-_____
- Social Work and Activities-_____
- Nursing and Medical-_____
- CNAs-_____
- Housekeeping and Laundry-_____
- Executive Director and DNS-_____
- Medical Director - _____
- Pharmacy - _____

Pause and Reflect

- How does the interdisciplinary team now compare to pre-COVID?
- Have people begun thinking about their post-COVID interdisciplinary team?
- What is the same?
- What is different?

Strategies to Prevent Hospitalization

- INTERACT
  - Designed for skilled nursing facilities
  - Focuses on early recognition of change in condition
  - Clinical and decision support tools
  - https://pathway-interact.com/
- OPTIMISTIC
  - Tools for transfer to and from hospital
  - Symptom management tools
  - OPTIMISTIC (optimistic-care.org)
- SBAR
  - Situation/Background/Assessment/Recommendation



Stop and Watch
Early Warning Tool

INTERACT
Version 4.0 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.

STOP
- Seems different than usual
- Talks or communicates less
- Overall needs more help
- Pain – new or worsening; Participated less in activities

and
- Ate less
- No bowel movement in 3 days; or diarrhea
- Drank less

WATCH
- Weight change; swollen legs or feet
- Agitated or nervous more than usual
- Tired, weak, confused, or drowsy
- Change in skin color or condition
- 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

Promising Treatment in Nursing Home: Monoclonal Antibody Therapy

https://youtu.be/JLLFKDFoHd4

Hospitalization: Clinical Indications

- Vitals become unstable despite interventions
- Urgent need for diagnostics and therapeutics
- Confirm goals of care are consistent with hospitalization

PROBARI

Best Practices When Transferring to the Hospital

Tips for transferring a resident to the hospital, and pre-transfer checklist. *Completed by nursing home staff* prior to transfer to hospital, travels with resident to provide ED staff with essential information

Decision to transfer a resident to the hospital should be based on:
Clinical considerations Is the resident clinically stable? Can we provide the diagnostic tests or treatments needed to care for this resident here? If COVID-19 is suspected, how will we isolate the resident and do staff have needed PPE? *Goals of care* Any medical orders regarding hospitalization, intubation, code status (such as POST form)? Have goals been re-addressed in the context of COVID-19?

https://www.optimistic-care.org/probari/covid-19-resources

Poll: Is your facility implementing the treatment?

1. Actively doing the monoclonal antibody treatments
2. Middle of planning for it and will be coming soon
3. Have not made any plans to use the treatment

The Model for Improvement
PDSA Cycles

Poll: How familiar are you with PDSA?

- 1. Very
- 2. Somewhat
- 3. What's a PDSA?

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

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Setting Aims

The aim should be time-specific and measurable; it should also define the specific population of patients or other system that will be affected.

Establishing Measures

Teams use quantitative measures to determine if a specific change actually leads to an improvement.

Selecting Changes

Ideas for change may come from those who work in the system or from the experience of others who have successfully improved.

Plan Do Study Act - PDSA

Testing Changes

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change in the real work setting — by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method adapted for action-oriented learning.

Small steps lead to big change

- Start small:
  - 1 day
  - 1 resident
  - 1 CNA
- Run multiple small PDSA at the same time
- Scale up as you build confidence that your change idea is working
- Slice your project into smaller pieces

PDSA Example – Engaging Patients

- Knock
- Introduce
- Sit
- Ask question

What improvements are you making?

- Who is on your team?
- What is your aim?
- What will you test?
- What will you measure?

What to expect next…

Next Session: February 19, 2021

Topics:

- Session 12: Promoting Safe Care Transitions during COVID-19

Send in your facility's best practices/challenges to Brenda Chen at bchen@maseniorcare.org

Wrap Up and Poll

- Please watch your screen and respond to our 2 poll questions as they launch

Questions?