Long-Term Care Survey Alert

Risk Management & Drug Safety News

Nurse attorney Kathy Hurst tells Eli that she's working with some facilities to help them develop shared risk assessment forms. The resident/family member sign the forms "to show that they understand the risks of the resident's condition and what the facility can do about those," says Hurst, owner and chief regulatory consultant for Hurst Consulting Group in Chino Hills, Calif.

The facilities' "original forms talked about the facility using fall protocols, which isn't a word you want to use. You should be individualizing various interventions," advises Hurst, owner and chief regulatory consultant for Hurst Consulting Group in Chino Hills, Calif. "Otherwise, a plaintiff attorney can say that you didn't follow [all the elements] in the protocol," Hurst adds. "You can, however, list interventions that could possibly be used."

As one example, "you can say to a family member: 'Your mother came in with a serious wound and we are not sure we can heal it but we will try and here's what we plan to do,'" Hurst explains. "If you require them to sign a form at admission that also says they had an opportunity to ask questions, etc., they at least can't say they weren't given the information," Hurst adds.

A study on the ABRAT (Aggressive Behaviour Risk Assessment Tool) demonstrated that "if [hospital] patients had at least two of the [tool's] marker indicators, they had a 41 percent chance of becoming violent, which is pretty significant," says **Kristyn Ideker, MSN, RN,** a researcher in the study.

More stats: "With a score of 1, 8.1 percent became violent," states an article by Ideker and **Son Chae Kim, PhD, RN,** on the study in the Journal of Advanced Nursing (J Adv Nurs. 2012 Feb; 68 (2):349-357). "As the ABRAT scores increased further, the percent of violent patients continued to increase and with scores [greater than or equal] to 4, 85.7% became violent," the article states.

"Being able to identify patients at risk for aggression really improves the quality of care and nursing safety," says Kim, professor of nursing at Point Loma Nazarene University in San Diego, Calif.

Potential downside: "If staff were forewarned, they would be more wary and could avoid injury," says Ideker, a nurse practitioner at Scripps Hospital in San Diego. "But if they avoid the patient or don't work up something that could be brewing," such as delirium -- that could be a problem, she tells Eli. Thus, "the tool needs to be used along with appropriate nurse education to help nurses identify the signs of delirium -- as well as how to deal with the aggressive patient." (For a free MDS Alert article on the ABRAT, e-mail the editor at KarenL@Eliresearch.com.)

Watch out: Giving too much acetaminophen can "result in significant hepatotoxicity -- even in patients with normal liver function," says **William Simonson, PharmD, CGP.**

"Guidelines vary but a common recommendation is to keep daily acetaminophen consumption under 4,000 milligrams. However, in some instances that limit might be inadvertently exceeded," adds Simonson, a consultant pharmacist and senior research professor of pharmacy practice at Oregon State University.

Cautionary example: "Recently I was reviewing medications in a nursing facility and found a resident who had a routine order for Tylenol® Arthritis Pain, 2 caplets by mouth every eight hours," Simonson tells Eli. "Since each caplet contains 650 mg of acetaminophen, this represents a daily dose of 3,900 mg -- very close to the daily limit."

More: "The resident also had an order for hydrocodone 5/500 tablet, a combination narcotic/acetaminophen medication [with 500 mg of acetaminophen in it] to be taken every four hours as needed for pain," Simonson adds. "Had the resident taken all of the tablets allowed by the prescription, that would have added an additional 3,000 mg of

acetaminophen for a total dosage of almost 7,000 mg, which is significantly into the danger zone."

A recent Food & Drug Administration drug safety communication states that the agency has "completed a safety review of the heart drug Multaq (dronedarone). This review showed that Multaq increased the risk of serious cardiovascular events, including death, when used by patients in permanent atrial fibrillation (AF)," the communication states. The FDA notes that "the Multaq drug label has been revised with the following changes and recommendations:

- Healthcare professionals should not prescribe Multaq to patients with AF who cannot or will not be converted into normal sinus rhythm (permanent AF), because Multaq doubles the rate of cardiovascular death, stroke, and heart failure in such patients.
- Healthcare professionals should monitor heart (cardiac) rhythm by electrocardiogram (ECG) at least once every 3 months. If the patient is in AF, Multaq should be stopped or, if clinically indicated, the patient should be cardioverted.
- Multaq is indicated to reduce hospitalization for AF in patients in sinus rhythm with a history of non-permanent AF (known as paroxysmal or persistent AF)
- Patients prescribed Multaq should receive appropriate antithrombotic therapy."

You can read the entire communication at www.fda.gov/Drugs/DrugSafety/ucm283933.htm.

You may not be familiar with the ICD-10 code set yet, but it continues to grow anyway. CMS recently posted the 2012 ICD-10 code update, which not only shows which codes were added, deleted, and revised this year, but also offers information on the new diagnosis coding system, which will be mandatory for providers Oct. 1, 2013.

Resource: For more on the 2012 ICD-10 changes, visit www.cms.gov/ICD10/11b14_2012_ICD10CM_and_GEMs.asp.

Editor's note: The preceding news item on ICD-10 was originally published in The Coding Institute's Part B Insider. To subscribe, call 1-877-912-1691.