



# Scripts

2nd Quarter 2010

"Where Service is not just a Word, it's a Way of Life!"

## **BAD THINGS CAN HAPPEN TO GOOD PEOPLE**

*Understanding Citations of Immediate Jeopardy*

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If you've been in the long term care industry for very long, you have likely noticed a change. One might argue that a deficient practice once assigned the scope and severity "D" might now be more often viewed as a "G." In turn, those citations once deemed a "G" now, often appear as a "J." To what do we attribute this change in practice?

There are likely many personal theories among consultants and clinicians as to why the perceived change; however, what has remained "unchanged" is Appendix Q of the State Operations Manual (SOM). Surveyors are readily and consistently applying Appendix Q as a guide in determination; hence, it would behoove the provider to also use this same guide to dictate day-to-day practice/prevention as well.

Per Appendix Q, Immediate Jeopardy is "interpreted as a crisis

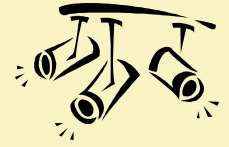
situation in which the health and safety of individual(s) are at risk. A situation in which the provider's noncompliance with one or more requirement of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." When first reading, one might shun this definition as not applicable to his/her facility; however, stop and think about it. How would you define "likely to cause?" So many times we, as providers, have brushed things off saying, "it was a one-time occurrence, no need to take additional action or go overboard, it isn't likely to happen again." If providers have been guilty of this nonchalant response to incidents, accidents, or allegations of abuse or neglect in the past, let's be clear that such response is unacceptable.

When we take the time to thoroughly review Appendix Q, it is noted that "only one individual



needs to be at risk when determining Immediate Jeopardy, AND serious harm, injury, impairment, or death does NOT have to occur before considering Immediate Jeopardy." These statements alone should bring pause to the rush of the day.

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## Employee Spotlight

**Debi Greek, RN, WCC, Kirk Seale, PharmD, and Judy Coon, RPh, CPh**

wrote an article on wound care,

***F-Tag 314 Compliance and the Importance of Pressure Ulcer Risk Assessment***,  
that will be featured in ***The Director***, a national nursing Journal.

## CONFUSING DRUG NAMES

Here are some examples of drug names that have caused confusion among nursing staff who enter medication orders into the nursing facility computerized medical record system.

### Metoprolol Tartrate vs. Metoprolol Succinate:

Toprol-XL® is a long-acting (extended-release) tablet which is available generically as Metoprolol Succinate. The shorter-acting (immediate-release) form of this medication is Metoprolol Tartrate, which is equivalent to the brand name, Lopressor®. Numerous errors have occurred when these medications have been confused by nursing facility staff during the medication order entry process. Please exercise caution when interpreting and entering orders for Metoprolol, and seek clarification if unsure about which form of this medication is intended.

### Isosorbide Mononitrate:

A tongue-twister that is also available as both an extended-release tablet (Imdur®) and immediate-release tablet (Ismo®, Monoket®). If you have trouble pronouncing this, try breaking it down: Iso-sorbide mono-nitrate.

All of these forms are available generically, so the pharmacy will dispense Isosorbide Mononitrate-ER for Imdur®, and plain Isosorbide Mononitrate tablets for Ismo® or Monoket®. To add to the confusion, there is an older drug called Isosorbide Dinitrate, which is still used. Errors have been observed due to confusion between Isosorbide Mononitrate extended-release and immediate-release. Additionally, confusion between the mono-nitrate and di-nitrate has resulted in errors, since they are not interchangeable. Please scrutinize Isosorbide orders carefully and clarify any orders that are confusing.

The worst part about errors caused by these confusing medications is that since both are considered cardiac drugs they have more potential to cause harm to your residents. Any errors with Metoprolol or Isosorbide would likely be considered significant med errors if discovered by surveyors.

As always, your Senior Care Pharmacy staff is ready to assist you when you have questions about these, or other confusing medication orders.



## ASK A PHARMACIST

### What constitutes a valid prescription for a controlled drug?

The Drug Enforcement Agency (DEA) requires a valid prescription (not a chart order) for all CII-V narcotics dispensed to a Skilled Nursing Facility. A valid prescription includes resident's full name, drug name, drug strength, dosage form, route of administration, quantity, directions, number of refills (CIII-IV) along with name, address, and DEA number of the prescriber, prescriber's signature and dated and signed on the day when issued. The prescription must be a written or verbal order directly from the prescriber or his agent.

If you would like to ask a pharmacist, please fax your question to 205-247-3399.

# BAD THINGS CAN HAPPEN TO GOOD PEOPLE

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Further, the serious harm, injury, impairment or death “may have occurred in the past, may be occurring at present, or be likely to occur in the very near future as a result of the jeopardy situation.” In short, providers must be evaluating past events, events of the day, and predict how events “could” occur in the future if that “one-time” event recurs due to lack of immediate and aggressive intervention.

Appendix Q questions whether the entity “created a situation or allowed a situation to continue which resulted in serious harm or a potential for serious harm, injury, impairment or death to individuals. Did the entity have an opportunity to implement corrective or preventive measures, but failed to do so?” These questions cause even the “seasoned” provider to scratch his/her head in contemplation.



If we are to evaluate the adequacy of our own actions/reactions, we must first understand the three components of Immediate Jeopardy. When an event of serious nature occurs in the facility, consider the following:

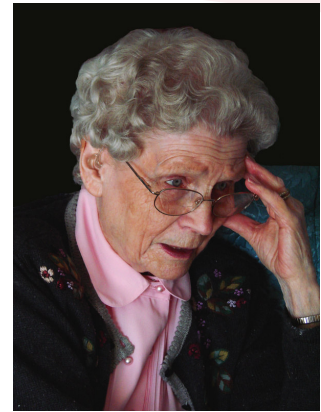
Harm- Was there an outcome of harm? If so, did the harm meet the definition of Immediate Jeopardy, e.g., the noncompliance caused serious injury, harm impairment, or death to an individual?

Immediacy- Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken?

Culpability- Did the entity know about the situation? If so, when did the entity first become aware? Should the entity have known about the situation? Did the entity thoroughly investigate the circumstances? Did the entity implement corrective measures? Has the entity re-evaluated the measures to ensure the situation was corrected? *In short*, “*what did we do about it?*” Did we stop dead in our tracks when notified late on a Friday evening and take immediate corrective action, or did we go ahead and leave the facility, planning to take care of it on Monday? Appendix Q warns, “the stated lack of knowledge by the entity about a particular situation does not excuse an entity from knowing and preventing Immediate Jeopardy.” It is anticipated that our management skills should assist us in identifying areas in which we are vulnerable, and compel us to continually improve care in manners such that our residents will not be placed at risk of serious injury, harm impairment or death. Our consistent monitoring to identify our own shortfalls (as part of an effective quality assurance program), can come to our rescue when contesting culpability.

While we need to take a firm stand if there was truly no indicator (or more commonly stated in the medical world—no “sign/symptom”) of an unfortunate occurrence which provoked a finding of Immediate Jeopardy, Appendix Q contends “the crisis situations in which an entity did not have prior indications or warnings, and could not have predicted a potential serious harm, are very rare.” Be forewarned. The resident who successfully eloped might have entries in the nurse’s notes reflective of prior exit-seeking behavior not reported to administrative staff (who would have ensured preventative measures, had they “known” about the behavior). The resident who assaults another resident is often no surprise to the third shift employee who casually

states, “I could have seen that one coming!” yet never reported their concerns to a supervisor.



How do we mitigate our risk of serious injury, harm, impairment or death? Take everything seriously, and take it seriously as a “team.” We are eager to talk of an “inter-disciplinary team,” but have we successfully convinced our management team to be “believers?” Do we respond to every event with a watchful eye and a preventative mindset?

Draft a plan of correction for everything!! If we look at the occurrence and, 1) fix it for the affected resident; 2) fix it for all other residents who might be at potential risk; 3) evaluate and revise the systems that failed us; and 4) continue to evaluate the efficacy of those revised systems in a routine manner, how can we go wrong?

Avoiding a citation of Immediate Jeopardy begins with understanding what constitutes Immediate Jeopardy and understanding that how we respond to day-to-day issues in our facility will dictate whether we place ourselves (and our residents) at risk of a citation of Immediate Jeopardy. Yes, bad things do sometimes happen to good people, but good people can also take both preventative and reactive measures to mitigate the risk of a finding of Immediate Jeopardy.

## WORD SEARCH

L P R E V E N R E L A T T D I A B E T S A  
 A A M O N A L E M D E T N E C T I O S W C  
 N E W O N T H L T I A A P R I L N E A N A  
 O R P A N U P A E A R P R E V E N T I O N  
 I H A J R T J T B B E H D L D E N U J I C  
 T T P R U E H E A E N A E A R P Y A M S E  
 A N R O P N N D I T E S T A N F O O T S R  
 N O I T C E T E D E S I W N L H N P N U J  
 A M N I K S E U S S I A P R I T C E T E D  
 M O N T N A L E M S H E A L H I H N N O M

### APRIL

Foot  
Health  
Issues  
Related  
to  
Diabetes  
Awareness  
Month

### MAY

Melanoma  
Skin  
Cancer  
Detection  
and  
Prevention  
Month

### JUNE

National  
Aphasia  
Awareness  
Month

## NEW DRUG UPDATE

### **Saphris® (asenapine)**

made by Schering-Plough, and is indicated for the acute treatment of schizophrenia and the treatment of manic or mixed episodes associated with bipolar disorder in adults. The tablet should be placed under the tongue and allowed to dissolve, do not swallow the tablet.

### **Silenor® (doxepin)**

made by Somaxon Pharmaceuticals, and is indicated for the treatment of insomnia characterized by difficulty with sleep maintenance. Silenor may be an effective therapy for those residents who experience complications from previous sleep therapies. It should not be combined with any other therapies and may not be for everyone.

**\*\*Remember not all new drugs are covered by Medicare Part D Prescription Drug plans.\*\***