Resident Safety is Everyone's Responsibility

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD

As the Founding Executive Director of the University of the Sciences in Philadelphia's Health Policy Institute, Dr. Stefanacci is building on his recent tenure as a Centers for Medicare and Medicaid Services (CMS) Health Policy Scholar. In that role, he spent a year working on policy development and implementation of the Medicare Part D Pharmacy Benefit, particularly regarding access issues for frail elders.

Dr. Stefanacci has a long and passionate history in long term care (LTC). Having served as medical director for several nursing facilities and continuing care retirement communities, he is well versed in the needs of LTC facility residents. Additionally, Dr. Stefanacci's geriatric experience includes over a decade as a medical director of a large primary care private practice, a full risk provider group, a Medicare + Choice (M+C) HMO, and a Program for All-inclusive Care for the Elderly (PACE) initiative in Philadelphia.

A graduate of A.T. Still University, Dr. Stefanacci completed his clinical training at the University of Medicine and Dentistry of New Jersey in Internal Medicine and a fellowship in Geriatrics at the same institution.

Dr. Stefanacci serves on the board of trustees at A.T. Still and previously for the National PACE Association. He also is an active member of the American Medical Directors Association (AMDA), American Society of Consultant Pharmacists (ASCP), and the American Geriatrics Society (AGS). Recently, he was recognized as an American Geriatrics Society Fellow (AGSF). In addition to writing and lecturing extensively, Dr. Stefanacci serves on the editorial boards of *Caring for the Ages, LTC Interface, Jefferson's Health Policy Newsletter, The Journal of Quality Healthcare,* and *Medicare Patient Management*.

Today's news is all too often filled with incidents of failures in resident safety—elopement resulting in a confused senior getting hit by a car, a resident falling and suffering a fracture because he or she was not attended to properly, a facility fire resulting in a resident's death. All of these cases are preventable if only facilities applied some basic safe practices. Successful safety programs are not just rewarded by simply keeping a facility out of the news. Rather, these programs afford facilities the opportunity to delight in healthy and happy residents. This does not occur by accident (no pun intended) but through careful planning and the involvement of the entire AL staff.

This issue of ALC focuses on resident safety. But unlike the news stories that focus on failures, our objective is to provide a roadmap to improved safety. It is important at the onset of this discussion that the entire AL staff realize that resident safety is everyone's responsibility, from the clinical staff to dietary and maintenance. All too often we assume that safety is someone else's problem.

Safety involves the marketing office and the intake coordinator, who must be cognizant of the important roles they play in matching residents' needs to the facility's abilities. Perhaps nowhere are safety issues more likely to end up in the legal system than in cases where a mismatch has occurred. Take, for example, the situation where a resident with Alzheimer's disease has behavior issues that manifest themselves in the form of wandering. If the facility is not prepared with either high-tech solutions or high-touch interventions, that resident is likely to find him- or herself outside the facility in trouble.

When we speak of high-tech solutions, we are referring to things like the use of automatic external defibrillators, which some states are requiring AL facilities to have. But some of the high-tech solutions on which clinicians have come to depend may not provide the answer, as first thought. For instance, a recent article in *The New England Journal of Medicine* examined the use of atypical antipsychotic drugs for Alzheimer's patients with behavior issues, which found that such medications did not relieve the disruptive behavior any better than a placebo. In addition, these medications were found to have safety issues that require black box warnings on their packaging.

Resident safety is everyone's responsibility, from the clinical staff to dietary and maintenance.

High-touch interventions include things like medication management, which can involve a consultant pharmacist reaching out to AL residents to educate, assess, and guide their medication programs. A thoughtful article in this issue describes the problem of inappropriate medication use, a problem that is drawing increasing attention in the AL industry. Indeed, the *Journal of the American Geriatric Society* pointed out in a recent article

Coming in

Assisted Living Consult

Advancing Senior Care Outcomes

January/February issue

A Look Toward the Future

- Report from the 2006 CEAL (Center for Excellence in Assisted Living) QUALITY SUMMIT
- Technology
- Accountability
- Affordability
- Behavior Management
- Physician House Calls

2007 National Patient Safety Goals: Assisted Living Version[1]

- Improve the accuracy of resident identification.
- Improve the effectiveness of communication among caregivers.
- Reduce the risk of healthcare-associated infections.
- Accurately and completely reconcile medications across the continuum of care.
- Reduce the risk of resident harm resulting from falls.
- Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- Encourage residents' active involvement in their own care as a resident safety strategy.

[1]http://www.jointcommission.org/NR/rdonlyres/27FAFA3A-DB22-4A8F-B2BE-310F41925DF9/0/07_ALF_NPSGs.pdf (accessed November 3, 2006).

that inappropriate medication use and under-use are common problems—found in more than 40% of the cases studied. These failures can result in falls, behavior problems, and worsening of chronic conditions that can create an unsafe environment.

As the clinical needs of residents increase, we are likely to find ourselves leaning on the AL clinical team more and more. While AL facilities have been slow to embrace clinical involvement in their facilities, they now are coming to realize that avoiding such involvement can increase their liability. As a result, AL facilities are working more closely with clinicians to provide better oversight of their residents. As we have continued to point out in our Interdisciplinary Team section, physicians are not the only ones responsible for the well-being of residents; the team should include the full complement of providers. In this issue we direct attention to the role of the psychiatrist. But no matter how many members of the team there are, their work has little value if there is no interaction with the residents and facility staff. Medicare has provided great assistance in this area by increasing the reimbursement for clinicians who see AL residents onsite rather than in costly and sometimes inaccessible offsite offices. As a result, we are beginning to see more onsite visits by clinicians, which results in improved assessment of resident care as well as improved collaboration with the AL staff.

Many groups have issued safety goals for AL residents; ALC has written about some of them and will continue to report on others. One group, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), has issued a report that especially is worthy of a read because it includes discussions of implementation and expectations of the safety goals they have identified.

It is important to remember that safety at your facility is not an issue that is ever done; rather, it is a constant process—one that should be in the back of everyone's mind during every activity in which they are involved. It is only through this constant focus that we can provide the highest quality of life for our residents, allowing them to age safely within the comfort of their AL homes. ALC

Richard G. Stefanacci, DO, MGH, MBA, AGSF, CMD
Editor-in-Chief
215-596-7466
rstefanacci@assistedlivingconsult.com