We MUST Reduce Antipsychotic Use Rates

*Using the QAPI Process to Make the Right Decisions*

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**Session Objectives**

- Review why this initiative is on the forefront of our industry’s consciousness
- Understand the 5 key elements and the relationship to the 12 Action Steps of Quality Assurance Performance Improvement (QAPI) in Nursing Homes
- Describe the initial steps to take to analyze antipsychotic use within the SNF
- Describe three key steps needed to apply the QAPI process to develop a Performance Improvement Plan (PIP) to improve dementia care throughout your organization

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**The Issue**

CMS S&C: 13-35 NH (May 2013)

- It has been a common practice to use various types of psychopharmacological medications in nursing homes to try to address behaviors without first determining whether there is a medical, physical, functional, psychological, emotional, psychiatric, social or environmental cause of the behaviors.
- The problematic use of medications, such as antipsychotics, is part of a larger, growing concern. This concern is that nursing homes and other settings (i.e. hospitals, ambulatory care) may use medications as a “quick fix” for behavioral symptoms or as a substitute for a holistic approach that involves a thorough assessment of underlying causes of behaviors and individualized, person-centered interventions.
Some History

- On March 29, 2012, the Centers for Medicare & Medicaid Services (CMS) launched the National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes (Partnership to Improve Dementia Care in Nursing Homes).
- The goal of this Partnership is to optimize the quality of life and function of residents in America’s nursing homes by improving approaches to meeting the health, psychosocial and behavioral health needs of all residents, especially those with dementia.
- While antipsychotic medications are the initial focus of the partnership, CMS recognizes that attention to other potentially harmful medications is also an important part of this initiative.

Some History...

- CMS’ Initial Goal:
  - Reduce national prevalence rate of antipsychotic medication use in long-stay nursing home residents by 15% by end of 2012
  - Baseline: national rate based on MDS data (Nursing Home Compare takes an average of previous three quarters) in December 2011 National rate in long-stay residents was 23.9%
  - This goal was not reached by the end of 2012 although there was a rate reduction of 6.45% when comparing Q4 2011 with Q4 2012
- CMS Quality Measure:
  - Percentage of long-stay residents who are receiving antipsychotic drugs in the target period.
  - Three diagnoses are excluded: Schizophrenia, Tourette’s and Huntington’s disease

Atypical Antipsychotics

- The atypical antipsychotics (AAP) (also known as second generation antipsychotics) are a group of antipsychotic tranquilizing drugs used to treat psychiatric conditions.
- Some atypical antipsychotics are FDA approved for use in the treatment of schizophrenia. Some carry FDA approved indications for acute mania, bipolar depression, psychotic agitation, bipolar maintenance, and other indications.
- Atypicals at the time of marketing were claimed to differ from typical antipsychotics in that they are less likely to cause extrapyramidal motor control disabilities in patients, which include unsteady Parkinson’s disease-type movements, body rigidity and involuntary tremors.
- More recent research has demonstrated the side effect profile of these drugs is similar to older drugs, causing the leading medical journal The Lancet to write in its editorial “the time has come to abandon the terms first-generation and second-generation antipsychotics, as they do not merit this distinction”
Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Conventional Antipsychotic Drug</th>
<th>Atypical Antipsychotic Drug</th>
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<tr>
<td>Chlorpromazine (Thorazine)</td>
<td>Ziprasidone (Geodon)</td>
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<td>Haloperidol (Haldol)</td>
<td>Olanzapine (Zyprexa)</td>
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<td>Fluphenazine (prolixin)</td>
<td>Quetiapine (Seroquel)</td>
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<td>Thiothixene (Navane)</td>
<td>Risperidone (Risperdal)</td>
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<tr>
<td>Trifluoperazine (Stelazine)</td>
<td>Clozapine (Clozaril)</td>
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FDA Black Box Warning

Simplified version: On a prescription for the antipsychotic medication Seroquel (quetiapine) from a national chain pharmacy, the following language appears:

Believe it or not

“Inappropriate use of psychotropic drugs lands former DON in prison, others plead "no contest"

- In a gross deviation from accepted standards of care, (the) DON would initiate Interdisciplinary Team (IDT) meetings where she directed the pharmacist to write prescriptions for antipsychotic drugs for residents she considered “troublesome.”
- The former medical director signed the orders after the IDT meeting—sometimes, three weeks after the medication was given.
- Moreover, he neglected to examine the residents to determine if the psychotropic medications were medically necessary, according to the AG.
- Astonishingly, when a resident refused the medications, she was “held down and injected with the psychotropic medicine by force”
- Three residents died as a result of the “convenience drugging,” while the others suffered serious adverse effects such as weight loss, lethargy, confusion and dehydration, according to official documents.
So, What Do You Do?

- The rate of antipsychotic use should be reduced (by 15%?)
  - You know it’s there
  - You know it’s a problem
- Addressing the problem requires focus, structure and a systems approach that is data-driven
- The framework: QAPI

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**THE FIVE ELEMENTS**

The Five Elements of QAPI

1. **Governance and leadership**
   - Facility administration
   - Accreditation
   - Staff members
   - Policies and procedures

2. **Feedback, data systems and monitoring**
   - Performance measures to evaluate care and services
   - Multiple sources of feedback
   - Performance indicators for a wide range of processes and outcomes

3. **Performance improvement projects (PIPs)**
   - Conduct PIPs
   - Identify priority areas that need attention for PIPs
   - Examine and improve care or services

4. **Systematic analysis and systemic action**
   - Systematic approach to determine when in-depth analysis is needed
   - Understand the problem, causes, implications of change
   - Structured approach to determine identified problems

5. **Quality assurance and improvement**
   - Redefine patient care
   - Continuously improve care
   - Evaluate and improve care
Element 3: Feedback, Data Systems and Monitoring

- Systems for gathering and analysis of data from multiple data sources
  - Staff, Residents, Families
  - Track and monitor adverse events (each time they occur)
  - Use a wide range of indicators to track performance compared to internal and external benchmarks
  - data accuracy
  - clinical quality measures
  - resident risk profiles
  - survey/compliance

Element 4: Performance Improvement Projects (PIPs)

- PIPs are conducted by facility to examine and improve care or services in areas needing attention
- Concentrated effort on a particular problem; one area or facility-wide
  - High risk
  - Problem prone
  - High frequency
- Systematic data gathering to clarify issues

Element 5: Systematic Analysis and Systemic Action

- Systems approach to performance improvement
  - In depth analysis to fully understand a problem, its causes and implications
  - Demonstrate proficiency in Root Cause Analysis (RCA); CQI and similar principles apply
  - Plan, Do, Study, Act PDSA applies to systemic action and PIPs
- Systemic actions look comprehensively across all involved systems to prevent future events and promote sustained improvement
  - Set appropriate goals
  - Develop action plans
- Monitor to ensure that interventions or actions are implemented and effective in making and sustaining improvements
QAPI AND ANTIPSYCHOTIC USE

Element 1: Design and Scope
Element 2: Governance and Leadership
Element 3: Feedback, Data Systems and Monitoring
Element 4: Performance Improvement Projects (PIPs)
Element 5: Systematic Analysis and Systemic Action

Develop a Strategy for Collecting and Using QAPI Data
Prioritize Quality Opportunities and Charter PIPs
Step 1: Leadership Responsibility and Accountability

- Senior leaders create an environment that promotes QAPI and is working on improving care and services
  - Provide guidance for the quality improvement initiative to achieve breakthrough levels of performance
  - Link the goals of improving dementia care and reducing the rate of antipsychotic use to the strategic priorities of the organization

Step 1: Leadership Responsibility and Accountability

- Senior leaders Choose QAPI lead(s)
  - Form Steering Committee which sets priorities and provides leadership
  - Include Administrator and DON as well as Medical Director
  - Current QA Committee can be adapted to QAPI
  - Consider Family and staff involvement in time-limited projects
- Provide resources for QAPI—including equipment and training
- Establish a climate of open communication and respect

Ask the Key Questions

- Do you know the facility’s rate of antipsychotic use?
- Is reducing that rate a strategic priority for the facility? Why?
- Have you declared your improvement goals?
- What will help you drive success in your quality improvement initiatives?
- What initiatives to improve dementia care are already underway or planned in your organization?
- How much experience do your executive leaders, mid-level managers, and front-line providers and staff have in process improvement? What resources (e.g., expertise in quality improvement, data analysis) are available to support improvement efforts?
- How will you provide oversight for the improvement
Step 2: Develop a Deliberate Approach to Teamwork

- An effective team includes:
  - Having a clear purpose
  - Having defined roles for each team member to play
  - Having commitment to active engagement from each member
- The roles of team workers may grow out of their original discipline
- Communication is key: within teams and across committees/workgroups

Step 2: Develop a Deliberate Approach to Teamwork

- Who are potential PIP team members?
  - Executive leaders such as directors of nursing, administrators, or other leaders supporting this work
  - Nurse managers, direct care staff, educators
  - Physicians including the SNF Medical Director, primary care physicians
  - Pharmacy Consultants
  - Family members, or other designated caregivers
  - Behavioral Management Specialists

Step 8: Identify Your Gaps and Opportunities

- Review sources of information to determine if gaps or patterns exist in your systems of care that could result in quality problems
  - National initiatives/best practice guidelines
  - Look at MDS data for patterns (Section E, Behaviors, Section N, Medications, Section I, Diagnoses, Section F, Preferences)
  - Check NHC (Quality Measures, staffing, survey)
  - Trends in complaints
  - Caregiver/family input on resident history
  - Staff Proficiencies/Training and Caregiver turnover
  - Clinical records
- Leads to PIPs
- Set realistic goals/targets—ST and/or LT
- Use benchmarks— a standard of comparison
The Antipsychotic Measure (Then and Now)

CMS has modified the previous SS and LS measures:
- Previous exclusions: Schizophrenia, Tourette’s Syndrome, Huntington’s Disease
- Psychotic disorder, Manic depression (bipolar disease), Hallucinations, Delusions
- The designation as a Surveyor Measure has also changed and both are now Quality Measures reported on NHC
  - 75th percentile is flagged

What are Your Benchmarks?

Looking for local benchmarks? Use NHC website to compare with other centers in your city.

Step 9: Charter PIPs

- Chartering implies that the team has been entrusted with a mission, and that it reports back to the Steering Committee at intervals
  - A PIP is more than a casual effort - it entails a specific written mission to look into a problem area
  - The PIP team should include people in a position to explore the problem (usually direct caregivers)
- Being part of a formally chartered PIP team must be interpreted as an important assignment that team members and their supervisors must take seriously
- PIP team establishes appropriate goals for organizational quality measures, informal improvement initiatives, and PIPs.
QAPI and Antipsychotics

- Facility QAPI committee identifies increased rate of antipsychotic use
- Further research reveals the rate has increased above national/state benchmark
- PIP is chartered and PIP team assembled
  - Nurse Manager, Pharmacy Consultant, Therapist, Medical Director, Nurse Educator, Behavior Specialist, CNA

Step 10: Plan, Conduct and Document PIPs

- During a PIP you will try out some changes and then see whether or not they made a difference in the area you were trying to improve.
- In the PLAN stage, the team learns more about the problem, plans for how improvement would be measured, and plans for any changes that might be implemented.
- In the DO stage, the plan is carried out, including the measures that are selected.
- In the STUDY phase, the team summarizes what was learned.
- In the ACT phase, the team and leadership determine what should be done next. The change can be adapted (and re-studied), adopted (perhaps expanded to other areas), or abandoned.
- Report back to Steering Committee

Step 11: Getting to the “Root” of the Problem

- Root Cause Analysis (RCA)
  - Primarily focuses on systems and processes, not individual performance
  - Structured method of analysis is designed to get to the underlying cause of a problem
  - Looks for the reasons behind the reasons. This process will generally lead to the identification of more than one root cause
  - Leads to identification of effective interventions that can be implemented in order to make improvements
- RCA focuses primarily on systems and processes, not individual performance
Getting to the root of the problem

- There is danger in starting with a solution without thoroughly exploring the problem. Multiple factors may have contributed, and/or the problem may be a symptom of a larger issue.

Root Cause Analysis (RCA)

- Assemble your team
  - Administrator, DON, Unit Managers, Medical Director to start
  - Additional members as needed: Pharmacy, Social Service, Behavioral and Psychiatric consultants, CNAs

- Analyze rate of antipsychotic use
  - Trend your rates over the past year, are you trending up or down?

- Ask the questions: How do you provide individualized care and services for residents with dementia and what are your policies related to the use of antipsychotic medications in residents with dementia?
  - Dose reduction?
  - Practices that promote behavioral health?
  - Non pharmacological intervention processes?
What are Your Rates?

Root Cause Analysis (RCA) cont.

- Current Practices
  - Are they adequate to need?
    - If not, why?
  - Are there committees dedicated to dementia care?
    - Antipsychotic reduction focus?
    - Behavioral management focus?
    - Both?
  - How often does the committee meet?
    - Not often enough? Why?
  - Who is on the committee?

Goal Setting: Using the SMART Formula

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<td>Relevant</td>
<td>Time-bound</td>
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- Specified: Outline the metrics to track.
- Measurable: Define the timeframe for the goal.
- Achievable: Identify the resources required.
- Relevant: Align the goal with the organization's objectives.
- Time-bound: Set a deadline for achieving the goal.
Our rate of antipsychotic use is __%, higher than both the state and national rates and our current process for behavior intervention, monitoring and dose reduction has not been successful in addressing this. It is both a quality and a compliance issue.

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**SPECIFIC**

What do we want to accomplish?
To reduce that rate and appropriately utilize this treatment

Who will be involved/different?
Clinical Managers, Pharmacy, PCPs, CNAs, Consultants

Where will it take place?
Facility wide, Specialty Unit, other specified units

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**MEASURABLE**

What is the measure you will use?
Rate from the LS Antipsychotic Quality Measure

What is the current data figure it is a, count, percent rate for this measure?
Current Rate: Internal calculation, CMS QM Rates, etc.

What do you want to increase/decrease that rate to?
Rate to be reduced by 15%
ATTAINABLE

Did you have the resources or time you needed to achieve your particular best practice/average score/benchmark?

CMS Initiative for rate reduction of 15% nationwide

Is the goal measure set too low, that it is not challenging enough?

Does the goal measure require a stretch without being too unachievable?

RELEVANT

Briefly describe how the goal will address the business problem stated above.

Provide for better quality dementia care for all residents, meet or exceed compliance requirements

TIME-BOUND

What is the target date for achieving this goal?

Set final and interim dates if needed

PDSA

- The team conducts small-scale tests of change in real work settings — by planning a test, trying it, observing the results, and acting on what is learned.
- Observation may inform improvement because it yields significant learning as a team tests and then implements changes
Step 2: Develop a Deliberate Approach to Teamwork (revisited)

- A typical front-line improvement team includes:
  - A Day-to-Day Leader for each pilot unit who will drive the work on their respective unit(s)
  - Residents, family members, or resident caregivers
  - Physician or nurse champion
  - Nurse practitioner or physician assistant (if applicable)
  - Nurse manager/supervisor, staff nurses, case manager, certified nursing assistant, nurse educators
  - Occupational therapist, Behavior Management Consultant

Planning: Creating an “Aim” Statement

- Once the actual change to be introduced has been agreed, the following questions should be asked:
  - What are we trying to do during this cycle?
  - What exactly will you do?
  - Who will be involved?
  - Where will it take place?
  - When will it take place?
  - What do you predict will happen?
  - What data/information will you need to collect?

Planning: What Does the Team Expect to Do?

- Review current protocols for behavioral health: what works? What is not working?
  - What protocols are in effect with your residents?
  - What is documented in the care plans?
- Staff competency and education
  - Training in dementia care (Who should participate?)
  - Are dementia care practices/guidelines included during orientation
- Staffing patterns
  - Consider a plan for consistent assignment
- Decide where to begin!
Planning: Where to Begin

- Start with reviewing all antipsychotic medications
  - Written as PRN because antipsychotics take 3-7 days before the effects start, which might deem them unnecessary
  - In use for 3 months or more to assess the possibility of discontinuation or gradual dosing reduction
  - In use for individuals admitted with these medication orders to investigate potential absences of psychotic indicators to identify opportunities to gradually decrease the medications
  - Initiated during evening/night/weekend shifts by implementing a review process to ensure that all such prescriptions initiated in the facility are critically evaluated within one week
  - That are off-label and used for appetite stimulation, smoking cessation, eating disorders or insomnia to determine if a non-pharmacological approach to these disorders might be more effective

SOM Appendix PP for F309 and F329

- For a resident with dementia, the facility is in compliance with F309, care for persons with dementia, if they:
  1. Obtained details about the person’s behaviors (nature, frequency, severity, and duration) and risks of those behaviors, and discussed potential underlying causes with the care team and (to the extent possible) resident, family or representative;
  2. Excluded potentially remediable (medical, medication-related, psychiatric, physical, functional, psychosocial, emotional, environmental) causes of behaviors and determined if symptoms were severe, distressing or risky enough to adversely affect the safety of residents;
  3. Implemented environmental and other approaches in an attempt to understand and address behavior as a form of communication and modified the environment and daily routines to meet the person’s needs;
  4. Implemented the care plan consistently and communicated across shifts and among caregivers and with the resident or family/representative (to the extent possible);
  5. Assessed the effects of the approaches, identified benefits and complications in a timely fashion, involved the attending physician

SOM Appendix PP for F309 and F329: Dementia Care Principles

1. Person-Centered Care. CMS requires nursing homes to provide a supportive environment that promotes comfort and recognizes individual needs and preferences.

2. Quality and Quantity of Staff. The nursing home must provide staff, both in terms of quantity (direct care as well as supervisory staff) and quality to meet the needs of the residents as determined by resident assessments and individual plans of care.

3. Thorough Evaluation of New or Worsening Behaviors. Residents who exhibit new or worsening BPSD should have an evaluation by the interdisciplinary team, including the physician, in order to identify and address treatable medical, physical, emotional, psychiatric, psychological, functional, social, and environmental factors that may be contributing to behaviors.
Dementia Care Principles

4. Individualized Approaches to Care. Current guidelines from the United States, United Kingdom, Canada and other countries recommend use of individualized approaches as a first line intervention (except in documented emergency situations or if clinically contraindicated) for BPSD. Utilizing a consistent process that focuses on a resident’s individual needs and tries to understand behavior as a form of communication may help to reduce behavioral expressions of distress in some residents.

5. Critical Thinking Related to Antipsychotic Drug Use. In certain cases, residents may benefit from the use of medications. The resident should only be given medication if clinically indicated and as necessary to treat a specific condition and target symptoms as diagnosed and documented in the record. Residents who use antipsychotic drugs must receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

Dementia Care Principles

6. Interviews with Prescribers. None of the guidance to surveyors should be construed as evaluating the practice of medicine. Surveyors are instructed to evaluate the process of care. Surveyors interview the attending physician or other primary care provider (NP, PA), behavioral health specialist, pharmacist and other team members to better understand the reasons for using a psychopharmacological agent or any other interventions for a specific resident.

7. Engagement of Resident and/or Representative in Decision-Making. In order to ensure judicious use of psychopharmacological medications, residents (to the extent possible) and/or family or resident representatives must be involved in the discussion of potential approaches to address behavioral symptoms. These discussions with the resident and/or family or representative should be documented in the medical record.

Planning and Doing

- Don’t target zero
  - Some residents do benefit from appropriate antipsychotic use
  - The key is to collaborate with physicians and psychiatrists and to ensure that antipsychotic medications are appropriately planned

- Learn about each individual resident
  - Assess for cognitive function, activities of daily living, and involvement in daily group recreational activities or therapeutic engagement
  - Identifying the frequency, intensity, duration and impact of behaviors, as well as the location, surroundings or situation in which they occur may help staff and practitioners identify individualized interventions or approaches to prevent or address the behaviors
Planning and Doing

- Family members are important as part of the process
  - Identify the preserved capabilities of the person with dementia, their previous and current interests, hobbies, and occupations, and their functional capacity
  - Design activities that match their capacity and interests
- Knowing detailed cultural, medical and psychosocial information about a person can help caregivers identify potential environmental or other triggers in order to prevent or reduce, to the extent possible, behavior or other expressions of distress

Planning and Doing

- Education
  - Developing nonpharmacologic approaches requires an entirely new way of thinking and new competencies
  - Competencies include knowledge about behaviors, how to read facial messaging about possible signs of underlying pain or infection, and how to read pre-clinical signs before behaviors such as agitation escalate
- Implement a strong behavior management program
  - On site team may include social services, recreational therapy, and nursing (certified dementia specialist)
  - Consultant psychologist or psychiatrist
  - Consider input from OT
  - Involve front line staff
  - Medical Director

Planning and Doing

- Individualized, person-centered interventions must be implemented to address behavioral expressions of distress in persons with dementia.
  - In many situations, medications may not be necessary
  - Staff/practitioners should not automatically assume that medications are an appropriate treatment without a systematic evaluation of the resident
Non Pharmacological Interventions

Examples of techniques or environmental modifications that may prevent certain behavior related to dementia may include (but are not limited to):

- Arranging staffing to optimize familiarity with the resident (e.g., consistent caregiver assignment)
- Identifying, to the extent possible, factors that may underlie the resident’s expressions of distress, as well as applying knowledge of lifelong patterns, preferences, and interests for daily activities to enhance quality of life and individualize routine care.
- Understanding that the resident with dementia may be responding predictably given the situation or surroundings. For example, being awakened at night in his/her bedroom by staff and not recognizing the staff could elicit an aggressive response.
- Matching activities for a resident with dementia to his/her individual cognitive and other abilities and the specific behaviors in that individual based on the assessment.

Test the Solutions

- Assess your program’s effectiveness
  - Review the residents’ behavior management records
  - PRN medications
  - Interventions prior to the administration of medications,
    - Medication effectiveness and any side effects
  - Interview front line staff
PDSA: Test the Changes (Why?)

- To decide which of several proposed changes will lead to the desired improvement
- To decide whether the proposed change will work in the actual environment of interest
- To decide which combinations of changes will have the desired effects on the important measures of quality
- To evaluate costs, social impact, and side effects from a proposed change
- To minimize resistance upon implementation

*Start small, observe the results, learn from them, and continue to the next test*

PDSA: Test the Changes (Why?)

- Most changes require a series of successive tests before implementation
- Testing may include
  - Adding more staff to try the change
  - Adding a variety of types of residents and family caregivers
- Learn as much as possible and create a process that is failure-proof (i.e., that works as reliably as possible).

PDSA: Testing the Changes

- Precisely specify the work, who does what, when, how, where, etc.
- Make use of human factors principles (e.g., build on existing habits)
  - Use checklists/communication tools to avoid relying on memory
  - Foolproof the process so that it is impossible to do the wrong thing
  - Use standard protocols and training
- If the responses vary, this may reveal a lack of reliability in how the work is done
- Make sure there is a process in place that identifies failures
  - Learn where failures occur and then design redundancies or remedies if they occur
PDSA: Testing the Changes

- Use data to process reliability
  - Track whether new and improved processes are executed as expected
  - Learn whether and how specific changes work as planned
  - When data suggest a lack of process reliability — ask the people who do the job what barriers they face
  - Identify opportunities to execute the new processes more reliably
  - Avoid blaming staff who do the work
  - Assume the problem is from poor process design
- Work with the team to fix it.

Step 12: Take Systemic Action

- Next you will want to implement changes or corrective actions that will result in improvement or reduce the chance of the event recurring
- This is often the most challenging step in the process
- Common solutions such as providing more training/education or asking clinicians to “be more careful” do not change the process or system

Step 12: Take Systemic Action

- To be effective, interventions or corrective actions should target the elimination of root causes, offer long term solutions to the problem, and have a greater positive than negative impact on other processes
- The goal is to make changes that will result in lasting improvement. Avoiding quick fixes and weak actions is vital to achieving that goal.
- In addition, interventions must be achievable, objective, and measurable
Classification of Corrective Actions

**Weak**
- double checks
- warnings/labels
- new policies, procedures, memoranda
- training/education
- additional study

**Intermediate**
- decrease workload
- software enhancements
- eliminate/reduce distraction
- checklists/triggers/prompts
- enhanced documentation, communication

**Strong**
- physical changes
- forcing functions or constraints (e.g. cannot continue charting until all fields completed)
- simplifying

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**Moving Forward: Process**

- Use of psychotropic medication requires skilled clinical assessment, consideration of risks vs benefits and evidence based approach
- Some questions to ask before prescribing:
  - What is the target problem
  - Is the drug really necessary
  - Are non-pharmacologic options available
  - Is this the lowest possible dose
  - Would discontinuation be more helpful
  - Does this drug have side effects, especially in the elderly
  - Is this the most cost effective choice
  - How and when will the effect of the drug be assessed

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**Moving Forward: Staffing Patterns**

- Staffing patterns
  - Appropriate number and type of staff?
    - Consistent assignments
    - RN support and oversight
    - Direct Care staff with adequate competencies
  - Collaborative interdisciplinary team for care planning;
  - Managing risk assessment r/t behavioral changes
- Physician / Physician Extender support
  - Evaluate your process for patient/resident evaluation by physician/physician extender
- Multidisciplinary team adequacy
Moving Forward: Education

- Staff Education
  - Elements for all staff levels
  - Orientation
  - Competencies updated and reviewed
  - Provide “background” information to put into context
  - (CMS “Hand in Hand” video)

- Resident and Family Input
  - Ensure resident and families have opportunity to contribute materials/information specific to the resident

QAPI Challenges

- Using data systematically to get a comprehensive overview of performance
- Turning data into meaningful information
- Building in systemic resident and family input without bias
- Structuring PIPs
- Applying root cause analysis
- Using systems thinking in all quality efforts
- Breaking out of silos of disciplines, departments, & shifts to work system-wide

QAPI Rewards

“Transforming the lives of nursing home residents through continuous attention to quality of care and quality of life”

- Competencies that equip you to solve quality problems and prevent their recurrence
- Competencies that allow you to seize opportunities to achieve new goals
- Caregivers become active partners in performance improvement
- Above all, better care and better quality of life for your residents

*S&C 11.22.99, April 2011
Resources

- Caralyn Davis, Staff Writer, LTC Leader 07.25.13: 9 Tactics to Reduce Antipsychotic Med Use http://www.almac.org
- REDUCING OFF-LABEL USE OF ANTIPSYCHOTICS Measurement Summary, ANCA/NCAL Quality Initiative
- “Antipsychotic Reduction Trend” dbh_behavioralhealth@cms.hhs.gov
- “QAPI at a Glance” http://go.cms.gov/Nhqapi
- CMS S&C: 13-35-NH, May 24, 2013; Advanced Copy: Dementia Care in Nursing Homes: Clarification to Appendix P State Operations Manual (SOM) and Appendix PP in the SOM for F309
- The Tennessee Advancing Excellence Coalition: http://www.qsource.org/addressing-dementia-antipsychotics/

Contact Information

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