State of Kentucky
Office of Inspector General
Division of Health Care
Training & Quality Assurance Branch

Making it Stick

QAPI Success:

Involving Everyone
From Plan to Action to Sustainability

Faculty:
Cathie Brady & Barbara Frank
B&F Consulting
August 2014

"Medicare continues its transformation from a *passive payer* to an *effective purchaser of high-quality, efficient care*."

Department of Health & Human Services
Fiscal Year 2014 Budget in Brief
Strengthening Health and Opportunity for All Americans
http://www.hhs.gov/budget

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Shari Ling, Deputy Chief Medical Officer, CMS Presentation at AHCA Quality Symposium - Feb 2014
From Passive Payer to Active Purchaser

FROM		TO
• Provider	→	• Person
• Volume	Medicare Commercial Medicaid	• Outcomes
• Fragmented		• Coordinated
• FFS	→	• Bundled

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Shari Ling, Deputy Chief Medical Officer, CMS Presentation at AHCA Quality Symposium - Feb 2014

A Culture of Continuous Improvement

- Robust Quality Assurance and Performance Improvement, as a way of doing business
- Quality Measurement, Benchmarking and Evidence Based Services for "highly valuable and predictable outcomes of care"
- Clinical Expertise and Performance
- Patient Centered Experience

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Shari Ling, Deputy Chief Medical Officer, CMS Presentation at AHCA Quality Symposium - Feb 2014

CMS Focus

Better health, better healthcare, lower cost

- Make care more effective
- Resident engagement in shaping care
- Care coordination and continuity
- Infrastructure for staff communication, engagement, critical thinking and continuous improvement

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Using all the government's levers to drive improvement

CMS Nursing Home Convergence Group

- From Volume to Value
- QAPI Driven Surveys and Plans of Correction
- Staffing
- Preventing Avoidable Declines

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Department of Health and Human Services OFFICE OF INSPECTOR GENERAL
ADVERSE EVENTS IN SKILLED NURSING FACILITIES: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES
Daniel R. Levinson Inspector General February 2014 OEI-06-11-00370

An estimated 22 percent of Medicare beneficiaries *experienced adverse events* during their SNF stays. An additional 11 percent of Medicare beneficiaries experienced temporary harm events during their SNF stays. Physician reviewers determined that 59 percent of these adverse events and temporary harm events *were clearly or likely preventable*. They attributed much of the preventable harm to *substandard treatment, inadequate resident monitoring, and failure or delay of necessary care*. Over half of the residents who experienced harm *returned to a hospital for treatment*, with an estimated cost to Medicare of $208 million in August 2011. This equates to $2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.

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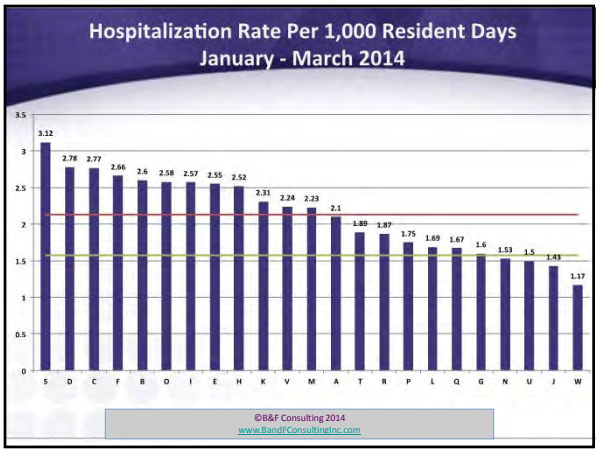
CYCLE TIME



Opportunity for Care Coordination: Potentially Avoidable Hospitalizations

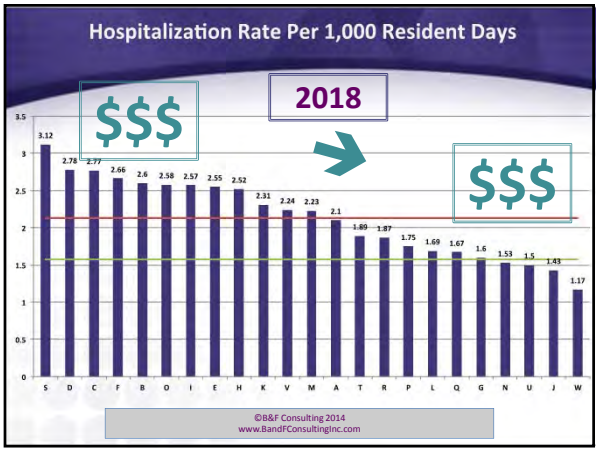
Potentially Avoidable Hospitalization rates vary across health care settings. Rates are highest for Medicare-Medicaid enrollees in skilled nursing facilities and lowest for those residing in community settings.

Five Conditions are responsible for over 80% of the PAHs:

-Congestive heart failure
-COPD, Asthma
-Dehydration
-Pneumonia
-Urinary tract infection

Summary Statistics on Medicare-Medicaid Enrollees and Potentially Avoidable Hospitalizations	
Percentage of hospitalizations that were potentially avoidable	**26%**
# of Potentially avoidable hospitalizations	**699, 818**
•Total costs in 2005	**$5.6 billion**
•Average length of stay	**6.1 days**
2011 estimated costs attributable to Medicare-Medicaid enrollees PAHs	**$7-8 billion**

Evan Schulman, CMS



Gone are the days of:

- CNA turnover and absenteeism are inevitable
- We're going to miss the mark, you can't expect more from us
- Can't get our nurses to do anything more than meds; they don't have the skills, time, or inclination
- Our physicians…
  - Would rather send them to the hospital to be safe…
  - Won't change a medication
- *That's the way we've always done it*

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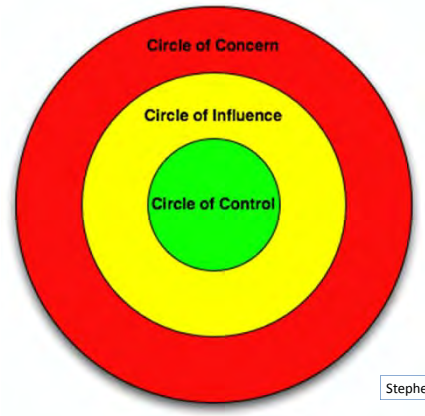

Stephen Covey

Goals for today

- Ready you for the brave new world of health care
- Identify causes of and ways to prevent avoidable adverse events
- Use QAPI practices to transform systems of care delivery for better outcomes

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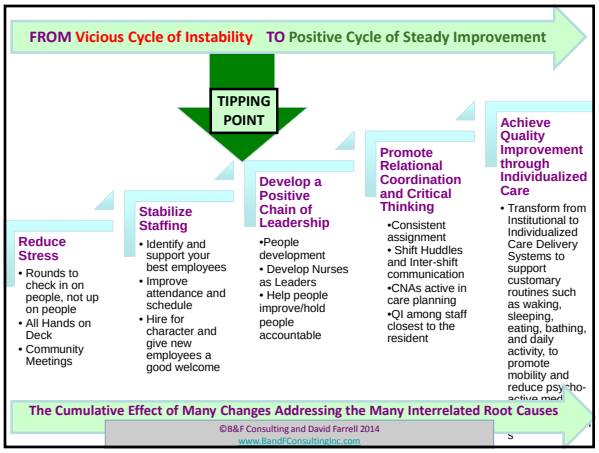

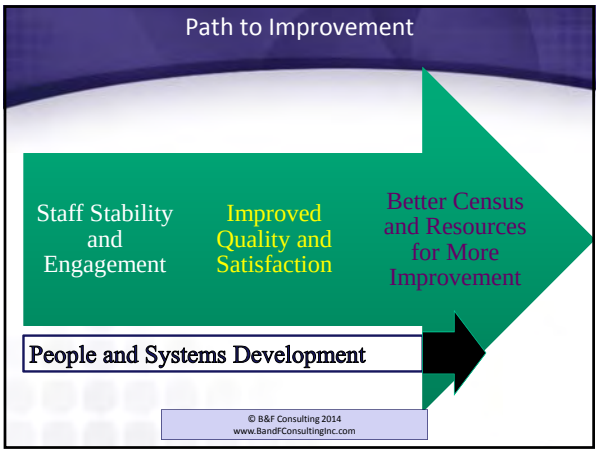
Path to Improvement
Staff Stability and Engagement
Improved Quality and Satisfaction
Better Census and Resources for More Improvement
People and Systems Development
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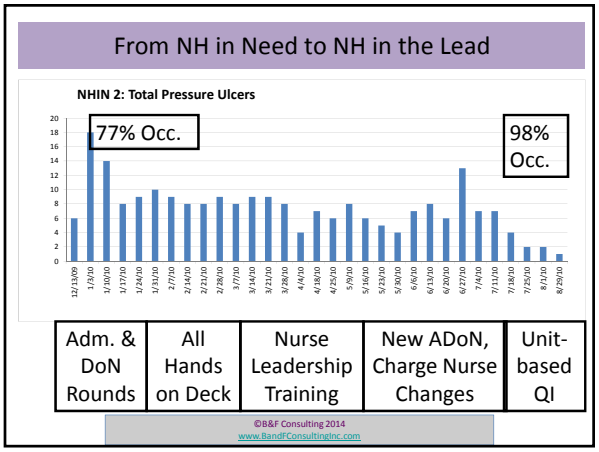
From NH in Need to NH in the Lead
NHIN 2: Total Pressure Ulcers
77% Occ.
98% Occ.
Adm. & DoN Rounds
All Hands on Deck
Nurse Leadership Training
New ADoN, Charge Nurse Changes
Unit-based QI
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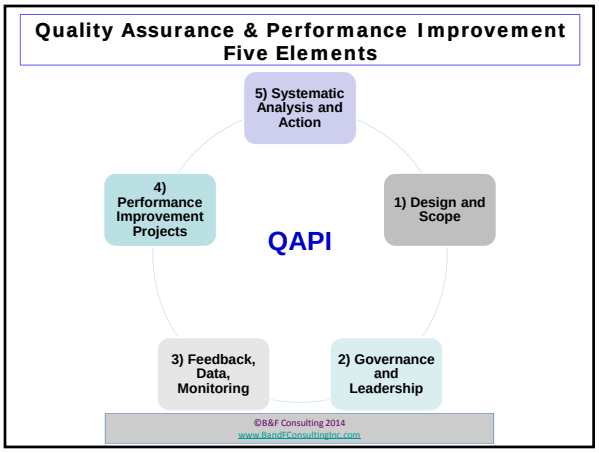
Quality Assurance & Performance Improvement Five Elements
5) Systematic Analysis and Action
1) Design and Scope
2) Governance and Leadership
3) Feedback, Data, Monitoring
4) Performance Improvement Projects
QAPI
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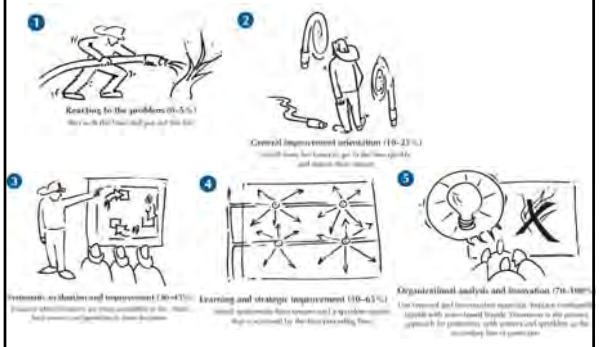
From Fighting Fires to Preventing Them



CRITICAL THINKING

Enhanced ~ Expansive ~ Analytical Thinking

Two Central Activities:

1. **Identify and challenge our assumptions**
2. **Explore and imagine options and act on them**

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Four key practices:

- **Lead with questions, not answers**
- **Engage in dialogue and debate, not coercion**
- **Conduct autopsies without blame**
- **Build "red flag" mechanisms**

Jim Collins

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Developing Critical Thinking as an Organizational Norm

- Welcome ideas
- Appreciate divergent viewpoints
- Make it safe to be challenged
- Routinely seek participation when making decisions

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OBRA 87

Requires each nursing home to provide care and services to:
attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident

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Consumer Perspective on Quality Care: The Residents' Point of View

National Citizens' Coalition for Nursing Home Reform

Kind Caring Staff + Who Know Me as a Person = Quality Care

And help me continue to be the person I am

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Highest Practicable =
No "avoidable" decline

Unavoidable =
natural progression of a resident's disease or condition

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Highest Practicable =
No "avoidable" decline

Avoidable = Iatrogenic = *We caused it*
"Genic" – Beginning/Cause
"Iatro" – We

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Premise # 1

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Premise # 2

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Mr. McNally:

What was he like when he first came in?

His decline was *not a natural progression of his disease*, so <u>what was the progression of actions that caused his decline</u>?

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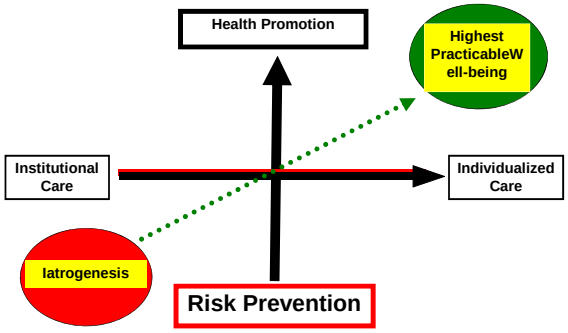
FROM IATROGENESIS TO WELL-BEING



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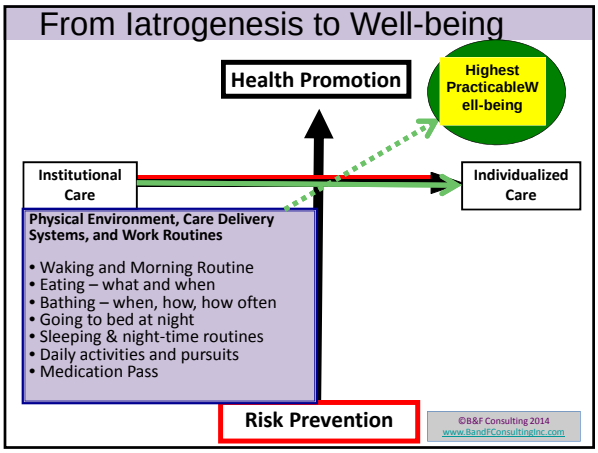

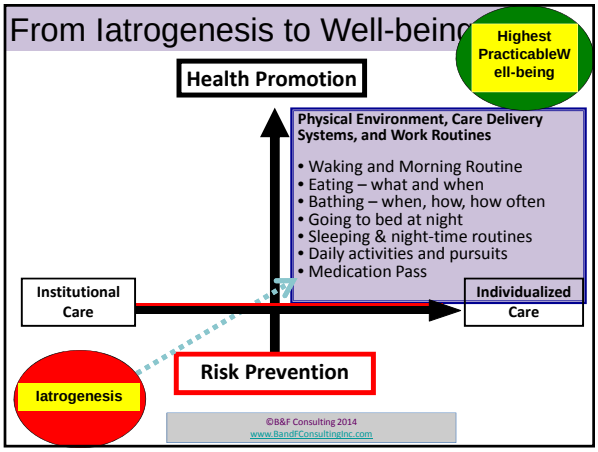

MDS Section F
Customary Routines

How important is it to you to:

A. Choose what clothes to wear

B. Take care of your personal belongings

C. Choose between a tub bath, shower, or other

D. Have snacks between meals

E. Choose your own bedtime

F. Do your favorite activities

G. Go outside to get fresh air

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Surveyor Resident and Staff Interviews

Choices over schedules to include: waking, eating, bathing, and going to bed at night, as well as health care schedules

Whether 11 years or 11 weeks

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Facility must:

- Actively seek information
- Be "pro-active" in assisting residents to fulfill their choices
- Make residents' choices known to caregivers

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CNAs ask five simple questions within an hour of a new person's arrival:

1. How would you like to be addressed?
2. What time do you want to shower?
3. What time do you want to go to bed?
4. What time would you like to wake up?
5. What would make you comfortable?

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As a result:

1. Fewer family complaints
2. Fewer rehospitalizations
3. Fewer missed therapy sessions
4. Better resident satisfaction from Day One

30% of rehospitalizations of nursing home residents occur for residents who have been in the nursing home for less than 7 days!

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Mr. McNally

How would knowing
Mr. McNally's customary routines
have prevented his declines?

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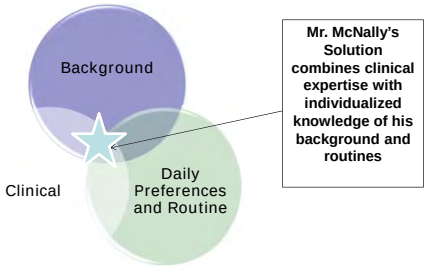
Engaging Staff in Individualizing Care:

Keys to QAPI Success

Individualized Care



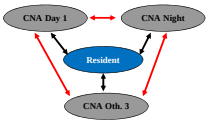
Pioneer Network

Material developed by B&F Consulting and Amy Elliott, PhD. for Pioneer Network's National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care funded by the Retirement Research Foundation

Engaging Staff in Individualizing Care:

Keys to QAPI Success

How Consistent Assignment Helps Mr. McNally



What's in the arrow? Resident communicates history, choices and clinical information

Black arrow – welcome process, consistent assignment, daily care – important information observed and noted

Red arrow – shift to shift hand-off through huddles or other communications (e.g., whiteboard, notebook) – important information engrained in daily care

Pioneer Network

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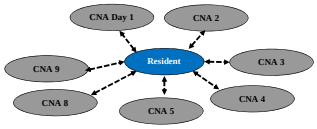
Engaging Staff in Individualizing Care:

Keys to QAPI Success

Mr. McNally without consistent assignment



What's in the arrow? Mr. McNally may communicate history and choices but key information potentially lost in the QI process

Pioneer Network

Material developed by B&F Consulting and Amy Elliott, PhD. for Pioneer Network's National Learning Collaborative on Using the MDS 3.0 as the Engine for High Quality Individualized Care funded by the Retirement Research Foundation

CUSTOMARY ROUTINES – KEY INFORMATION

- **Knowing customary routines prior to or immediate upon arriving**
- **communicate these routines across shifts and departments**
- **be a part of making a game plan to accommodate these routines**

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Customary Routines:

How can you improve your
cycle time
for getting this information
to the people who need it
on Day One?

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Map your current process

Current process:
Who gets this information, when, and how is it shared?

How could you improve this process?

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Take a Break

Soldiers Story

From The Leadership Challenge
by Kouzes and Posner

The Power of Information
to drive performance when
it's given to those performing

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The first group of soldiers
were told the exact distance
they would march
– 20 kilometers –
and were regularly informed of
their progress along the way.

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Group two soldiers were told
only, "This is the long march
you heard about."

No one knew exactly how far
they would march, nor were
they informed of their progress
along the way.

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Group three soldiers
were told they would march
15 kilometers.

After marching 14 kilometers,
they were told they had 6 more
to go.

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The fourth group of soldiers
were told they would march
25 kilometers.

After marching 14, they were
told they had only 6 more to go.

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So how did they do?

Which group did the best,
and suffered the least?

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No surprise –
Group one performed the best.

Knowing how far they were going and getting regular reports were the keys to achieving the highest ratings.

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Group two performed the worst.

Not knowing
how far they had to march and then getting no information along the way
yielded poor results.

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Group three came in second.

When this group learned
that they had farther to go
they just pulled harder.

To some this was surprising.

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Group four finished third. Apparently, it's more of a letdown to think you have farther to go and then learn you have less, than to learn you have more.

It appears to take the spring out of your step.

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Blood tests for stress indicators were taken throughout the march and again twenty-four hours later.

The results corresponded with the finish times.

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Information is powerful when shared

When you have pertinent information, you perform better.

Data on your destination and your progress gives people a roadmap, a sense of direction, and feedback about where they are in their journey.

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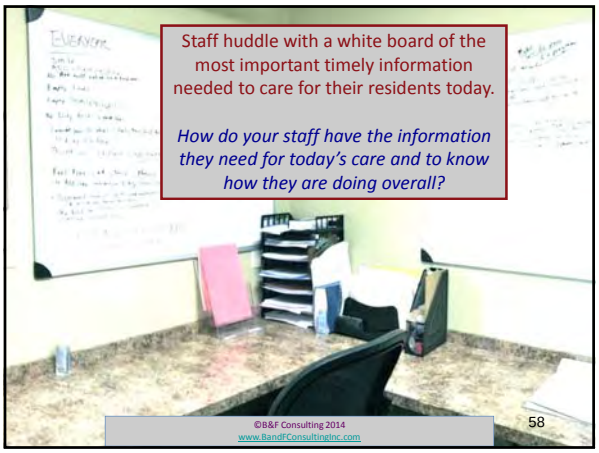

Relationships Determine Outcomes

- Quality, the **result**, is a function of quality, the **process**
- Cannot continuously improve interdependent systems and **processes** until you progressively improve interdependent, interpersonal **relationships**

Covey, 1991

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Theory of relational coordination:

- Relationships with the resident are shaped by the relationships among all those who are caring for the resident
- It is the *community* of relationships that shapes the resident experience

Jody Hoffer Gittell
Brandeis University

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Dimensions of Relational Coordination

Interdisciplinary ~ Interdepartmental
Across Shifts and Days

Communication
- **Frequent**
- **Timely**
- **Accurate**
- **Problem-solving**

Relationship
- **Shared Goals**
- **Shared Knowledge**
- **Mutual Respect**

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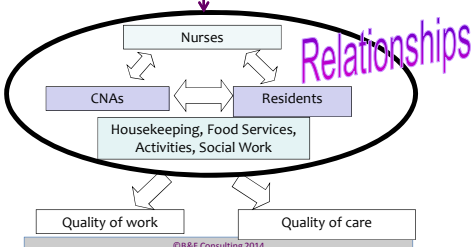
Relationships Closest to the Resident Matter Most

Interdisciplinary and Interdepartmental Collaboration within and across units and shifts



Quality of work | Quality of care

Eaton, Bishop, Gittell

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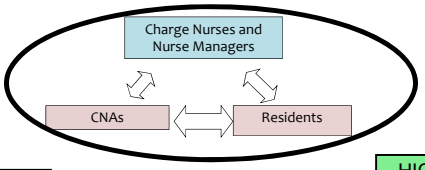
Relational Coordination: Shift Hand-off



LOW: Tape recorder ⟷ HIGH: Person to person with shift overlap

Communication and Relationship Factors

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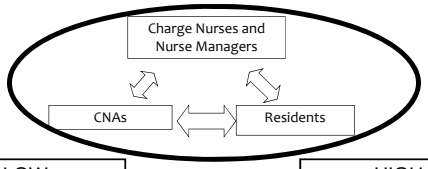
The First 24 Hours



LOW:
Staff closest to a new resident know nothing about the person before arrival and in first 24 hours, and have no way to share what they learn

HIGH:
Staff closest to a new resident receive and gather key information as soon as possible and share what they learn with care team partners

Communication and Relationship Factors

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If Mr. McNally
is hospitalized with:

Constipation, fecal impaction, Dehydration, UTI, Weight loss, nutritional deficiencies, and Altered mental status….

Was his hospitalization avoidable?

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It's all about prevention

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What is CMS Looking at as? "Potentially Avoidable"

- COPD, chronic bronchitis, and asthma
- Congestive Heart Failure
- Constipation, fecal impaction
- Dehydration, volume depletion, including acute renal failure and hyponatremia
- Hypertension and hypotension
- Poor glycemic control
- Seizures
- Urinary tract infections

Dr. Claire Hays,
AL Innovation Project

CMS "Potentially Avoidable"

- Weight loss, failure to thrive, and nutritional deficiencies
- Altered mental status, acute confusion, and delirium
- Anemia
- Diarrhea, gastroenteritis, c. difficile
- Falls and trauma
- Pneumonia and bronchitis
- Psychosis, severe agitation, organic brain syndrome
- Skin ulcers and cellulitis

Dr. Claire Hays,
AL Innovation Project

Hospitalization Drivers in Your Control

- **Staff Skills and Systems**
  - **Nursing Skills/Competencies**
  - **Lack of Early Detection**
  - **Poor Communication Between Disciplines**
  - **Poor Documentation**
  - **Poor Utilization of INTERACT Care Paths**
  - **Nursing Staff Discard Completed STOP AND WATCH**
  - **Limited Testing Within NF in a Timely Manner**
  - **Poor Utilization of Consistent Assignment**
  - **Staff Turnover**
- **Choice:**
  - **Staff Do Not Feel Comfortable Treating In House**
  - **Lack of Advance Directives/ Proper Advance Directives**
  - **Family Choice**
  - **Physician Request**

Dr. Claire Hays,
AL Innovation Project

Improve our Cycle Time

- Recognize early changes in resident condition
- Improve communication
  - Among staff
  - With practitioners
  - With residents and families
  - With hospitals/Ers
- Act effectively using best clinical skills

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Scenario

Could this hospitalization have been avoided?

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www.ahrq.gov Team STEPPS

http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/longtermcare/video/02stry1_bad/index.html

Note early warning signs and time

Time	Early Warning Sign

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Scenario - Discuss

What were the
early warning signs?

What were the opportunities
to communicate them
and act on them?

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Acute Change in Condition

- **Sudden** and **Clinically Important** deviation from patient's baseline
- Physical, cognitive, behavioral, or social domains
- A deviation that, without intervention, could result in complications (hospitalization) or death

For nursing home residents, very subtle changes can be ***early warning signs*** of a clinically important change in condition

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Stop and Watch

STOP

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

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Stop and Watch

AND

- Ate less
- No bowel movement
- Drank less

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Stop and Watch

WATCH

- Weight change
- 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

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Stop and Watch

- To guide direct care staff through a brief review of early changes in resident's condition.
- To improve communication between frontline staff and the nurse in charge about early changes in condition.

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Stop and Watch

Who can use it?

Everyone!

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If staff had completed a Stop and Watch, what clinical action could have been taken?

Time	Early Warning Sign	Intervention

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www.AHRQ.Gov Team Stepps SBAR

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When early warning signs are *noted, communicated, and acted on*, preventive treatment can begin right away.

How can you ***engineer*** this into your systems so that it happens automatically?

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CYCLE Time in Your Nursing Home

How do early warning signs get to the clinical leadership team who can act on them?

How long does it take?

Map your process

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Watch List – At Risk List

Who's on your Watch List?

How are people added to watch list?

How do you watch them?

How do people know what to do about someone on watch list?

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Relational Coordination for Start of Shift

LOW: Everyone just goes to their own assignment ↔ HIGH: Rounding/Huddle review of each resident at start of shift

Communication and Relationship Factors

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Relational Coordination for End of Shift

LOW: Everyone just does their paperwork and goes home ↔ HIGH: Rounding/Huddle review of each resident at end of shift

Communication and Relationship Factors

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Huddle How-to

- What you cover:
  - By exception, any red flags - risks and opportunities, appointments, test results.
- How long:
  - 10 - 15 min.
  - Keep it moving and constructive, relevant and brief
- How to do it:
  - You can use the 24 hour report to guide your focus, or go resident by resident
  - CNAs provide relevant information about their residents; nurses provide medical information and context, what to watch for; teachable moments
  - Problem-solve together and make a game plan

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Support for Shift Huddle Success

- Consistent Assignments
- Leadership and facilitation skills of nurses
- Regular nurses meetings on leadership development, at risk residents, workforce and workflow
- True problem-solving so what CNAs bring up is acted upon with follow-up
- Integrated into QI process
- Timely, helpful participation of other departments

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Options to Get a Shift Huddle Going

- Focus on new residents - heads up before they come; check in the next day
- INTERACT[II] "Stop and Watch"
- Anyone in their ARD
- At risk residents
- As needed, on the spot, safety huddle
- QI areas (falls, wounds, antipsychotics)

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Tips for Nurses for Effective Huddles

- Use "*teachable moments*" to help CNAs to know the implications of the information they're sharing
- Follow-up with CNAs – *close the loop* – let them know what happened with the information they shared

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Facilitating Huddles Effectively

is a developed skill

Like any skill,
it gets better with
practice and mentoring

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Facilitation How-to's

How do you guide staff to contribute constructively?

How do you draw people out?

How do you generate problem-solving?

How do you keep on task?

How do you keep on time?

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Huddles

at Mr. McNally's Home,
Glenridge Living Communities
Augusta, Maine

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Pioneer Network — Integrating the MDS 3.0 Into Daily Practice

Shift Huddle - at Glenridge Living Communities:

Develop the Process

- CNAs
  - Identify risks & resident's status
  - Give overview of the previous shift report and pertinent events of this shift, including quality of life events
- Nurses
  - Identify any acute medical changes & the follow up plan
  - Address any changes or additions to the plan of care

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Pioneer Network — Integrating the MDS 3.0 Into Daily Practice

Other Disciplines

- Social Worker: Adds pertinent psychosocial needs and *Life Story* information. Also shares what the resident interview revealed and family requests or concerns.
- Activities: Identifies "*Quality of Life Preferences*" for this resident, how they are adjusting socially and what is planned for them.

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Team Communication

- Dietitian/Diet Tech: Addresses what is on the POC for nutritional support and solicits feedback.
- Therapy: Shares the goals and gives tips on how the nursing team can assist the resident meet those goals.
- DON & Administrator:
  - Provide support when staff expresses a need that would help them improve their care.
  - Give positive feedback on what has been presented so that the staff know it is valued

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Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Shift Report- Examples

- CNA: "I am reporting on Frank. He is a fall risk and is at risk for skin breakdown. He was restless after breakfast, so I took him for a walk. His balance was pretty good; no falls. He napped in the recliner for an hour and then he ate 90% at lunch. His skin was without red areas when we brought him to the bathroom after lunch. Please take him to see the visiting animals at 4:00."
- Nurse: "Frank has had a med reduction so let me know if you notice increased agitation."

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Pioneer Network Integrating the MDS 3.0 Into Daily Practice

Shift Report- Examples

CNA:"I am reporting on Mrs. Jones. She is in the ***Spotlight*** this week. She is at risk for weight loss, ate 90% of breakfast and 40% of lunch today. She is drinking well. She is also at risk for skin breakdown; her heel hover boots and elbow protectors are on. She was last repositioned at 2:30 so is due right after report.

She also has a history of depression, but seems to be her normal self. Her family was in to visit at lunch and she enjoyed the music activity. She requests a shower this evening."

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Nurse: "Please let me know when you help get her undressed for the shower as I need to do a complete skin assessment. Let's check her weight at that time as well."

Diet Tech: "We provide fortified cereal and a high protein snack for Mrs. Jones to support her need for nutrition. Let me know if she starts refusing them. Also, have you noticed if she has favorites that we can offer more often?"

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Social Worker: "Mrs. Jones' daughter tells me this time of year has always been difficult for Mrs. Jones as she lost a child in the summer, so we should be looking for signs of sadness. Please let me know if you notice her wanting to stay in her room more often."

Activities: "Mrs. Jones is very social lately; has been enjoying Bible study and the music entertainment. I've noticed that she is more willing to interact with others."

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Pioneer Network — Integrating the MDS 3.0 Into Daily Practice

Shift Report- Examples

- CNA: "I am reporting on Sally. She's not her normal self today, is quite lethargic. She was up until 4am this morning, which is unusual. She ate a sandwich, tea and ice cream during the night. She slept through breakfast, ate a bowl of cereal and a donut and coffee around 10:30, and then refused lunch. She drank about 4 oz. of an Ensure at 2pm. Please offer her a drink and snack after report."

"She is at risk for falls and is more unsteady today: I had to provide extensive assist with transfers. Normally I have to only provide supervision or limited assist."

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Integrating the MDS 3.0 Into Daily Practice

- Nurse: "Sally has been started on an antibiotic for a UTI; please check her vital signs this evening. Let me know if she eats less than 50% at supper and offer extra fluids this evening."
- Activities: "Sally enjoys listening to Frank Sinatra and I have a new CD for her in her room. Perhaps this will help her sleep tonight".

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Huddle tipsheet
At
www.PioneerNetwork.net

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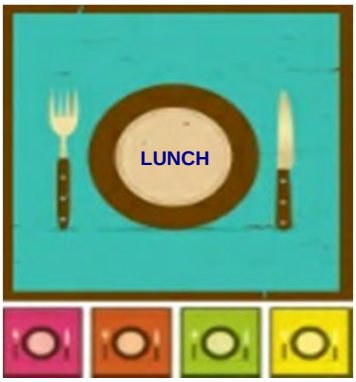

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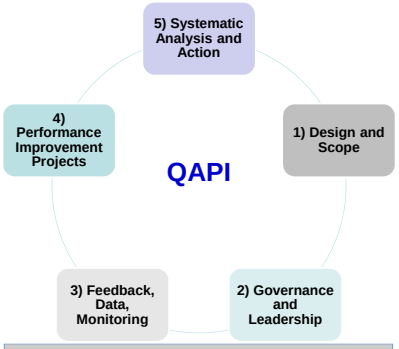
Quality Assurance & Performance Improvement Five Elements



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Governance and Leadership: QAPI at a Glance

Establish a climate of open communication and respect. Leadership may wish to consider:

— Having an open-door policy to communicate with staff and caregivers.

— **Emphasizing communication across shifts and between department heads.**

— **Creating an environment where caregivers feel free to bring quality concerns forward without fear of punishment.**

— Understand your home's current culture and how it will promote performance improvement:

— Create the expectation that everyone in your nursing home is working on improving care and services.

— **Establish an environment where caregivers, residents, and families feel free to speak up to identify areas that need improvement.**

— **Expect and build effective teamwork among departments and caregivers.**

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QAPI Calls for

A Culture Change
in
Leadership

Let's look at the evidence

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A Positive Chain of Leadership

What a difference management makes!
Five Management Practices Associated with
Low-Turnover, High Attendance
and High Performance:

- **High quality leadership at all levels of the organization**
- Valuing staff day-to-day in policy and practice, word and deed
- High performance, high commitment HR policies
- Work systems aligned with and serving organizational goals
- Sufficiency of staff and resources to care humanely

Eaton, 2002

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Level Five Leaders

Builds enduring greatness through a *paradoxical blend of personal humility and professional will.*

They are a study in duality:

- *modest and willful*
- *humble and fearless*

Jim Collins
Good to Great

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Myth:
Leaders are born, not made.

Fact:

Leadership is not in a gene;
it is an observable, learnable set of practices.

The belief that leadership can't be learned is a powerful deterrent to leadership development.

Kouses and Posner
The Leadership Challenge

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My InnerView Findings
Staff recommend your place to work if:

CNAs	NURSES
1 Help with job stress and burnout	1 Help with job stress and burnout
2 Management listens	2 Management listens
3 Management cares	3 Management cares
4 Supervisor appreciates	4 Training to deal with difficult residents
4 Adequate equipment/ supplies	4 Training to deal with difficult family members

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QAPI At-A-Glance
Leadership Responsibility

Create a *culture of engagement* in problem-solving and performance improvement

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"Quality is everyone's responsibility."

W. Edwards Deming

David Farell 2012

QAPI requires high engagement and inclusion

To have high engagement for QAPI, it needs to be part of everyday practice

Action Step:

A Regular Positive Leadership Presence that Staff Can Rely on

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Leadership that Builds Trust

- Presence
- Listening - Asking and delivering
- Consistency
- Speaking with conviction – Being Transparent
- Let your staff know what you've done

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Leadership Visibility

Consistent Presence:
- Rounds
- Huddles
- Community Meetings
- Stand-up on the Floor

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VIDEO

A Leadership Presence Staff Can Depend On

Meeting With Staff Closest to the Residents

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DISCUSS AT YOUR TABLES

How do you maintain a regular positive presence that your staff can depend on?

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Consistency = Credibility

- "It worked, but it fell by the wayside…"
- "Good idea! We can do that…"
- "We'll meet every Tuesday at 11:00…"
- We meant to do that, but, you know…things come up…"

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What a difference management makes!
Five Management Practices Associated with
Low-Turnover, High Attendance
and High Performance:

- **High quality leadership at all levels of the organization**
- Valuing staff day-to-day in policy and practice, word and deed
- High performance, high commitment HR policies
- Work systems aligned with and serving organizational goals
- Sufficiency of staff and resources to care humanely

A Positive Chain of Leadership Throughout the Organization

Eaton, 2002

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Your QAPI Success
Depends on Everyday Teamwork

Everyday teamwork requires nurse leadership.

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Leadership on the Floor
How 2 charge nurses start their day

"I gather my staff in the morning and I tell them, 'we have to work together. We're like sticks. If we work apart, each of us can be broken. If we stick together, we can't be broken. We've got to stick together to get the work done. And let's have fun doing it.' Then I just pitch in and we get through the day."

"I am overwhelmed by what I have to do when we're working short. If I start doing the CNA's job, I'll never get all my meds passed and my charting done. It's just too much. I'm not going to do the personal care. I just keep my focus on my work and get as much done as I can."

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QAPI requires high engagement and inclusion

To have high engagement for QAPI, it needs to be part of everyday practice

Action Step:

People Development

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People Development

You cannot do it alone!

We have always know this to be true…
and now CMS is mandating an inclusive process

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This calls for *transformational* leadership

- You're looking for your staff to contribute to on-going performance improvement by:
  - Being critical thinkers
  - Contributing ideas
  - Bringing their questions
  - Looking at data
  - Identifying solutions
  - Being analytical
  - Leading or participating in PIPs

This is a huge shift from
"we have a policy and procedure for everything"

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Benefits of Developing Leadership

- Having a deep bench
- Loyalty
- Ensuring succession
- Success with QAPI!

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Helping people step into engagement

- Small opportunities
- Time to attend meetings (others may have to cover their duties)
- Guidance
- Feedback

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As you are touring your building, be on the lookout to note staff's QAPI potential

Early

Early identification *of staff who show signs of QAPI potential is the first step towards providing them with opportunities*

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Consider their life experiences

What leadership opportunities have staff been involved with outside of work?

Remember:

Leadership is a skill;

the more you do it the better you get at it.

Many of your staff have had leadership opportunities outside of work that will be beneficial to you as you take on QAPI.

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To develop and support emerging leaders, provide them with **Variety** with **Support**

Variety

- People develop most when change is needed
- Anything new is a change: New people, new skills
- QAPI is new. Consider QAPI a growth opportunity for your staff.

Your organization will become better at QAPI and you will be developing your staff

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What **Support** Looks Like

- Pay attention to each person's development. Don't let their development be unplanned.
- Think about: *What will this person have to learn quickly? What will they have to unlearn? Give up doing?*
- Actively help them think through areas they are uncertain of.

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Provide lots of feedback

- Feedback is crucial, and should be given regularly. Let them know *what they're doing well because they won't know it unless you tell them*
- QAPI projects will need a lot of attention; talking things through with individuals involved will be essential to your success

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Aggressively help them learn from each experience

- Successful people are active learners
- Give them opportunities for reflection by debriefing with them about the project and then by reviewing upcoming opportunities.

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Be transparent: Let them know that by taking on a role in QAPI you are giving them an opportunity for leadership development

- *There is no leadership DNA*; like any other skill the more you do it the better you get at it.
- *I am a work in progress* – their success is your success!

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Think about the opportunity
QAPI presents for your staff

Who comes to mind?
What can you do?

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People Development Worksheet

Identify individualized ways to develop your charge nurses

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People Development Worksheet

Employee	Core Strengths	Opportunities for Growth	Ways to Support Strengths and Growth
Shining Star			
Steady Eddy			
Diamond in the Rough			

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Take a Break

Consistent Assignments

The Silver Bullet

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The *Why* of Consistent Assignments

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The *Why* of Consistent Assignments

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Receiving Intimate Care is Emotionally Difficult

How Care is Provided Really Matters

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The *How* of Consistent Assignments:

What's Needed for Consistent Assignment to Work

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Staff engagement in the process:

NC DoN wanted to develop and engage CNAs and charge nurse in piloting improving consistent assignment so she had one CNA collect data on:

How many different CNAs is a resident receiving care from?

and another CNA collect data on:

How many times are "consistent" CNAs moved to another assignment to cover an absence?

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How consistent are you?

You have it in theory…do you have it in reality

Measure your current practice:

How many different CNAs is a resident receiving care from?

How many times are "consistent" CNAs moved to another assignment to cover an absence?

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How-to Basics for Dedicated Assignment

- A Good Process
  - Fair distribution of work
  - Matches work for residents and staff

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Process for Weighting and Balancing Assignments

Rate each resident on scale of 1 – 3 in each dimension – physical and non-physical factors

Resident	Physical	Non-physical	Total

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How-to Basics for Dedicated Assignment

- Charge nurse support
  - Adjust as needed
  - Support for residents staff find challenging
- Include nurses, housekeeping, activities, SW
- **Revisit periodically for changes in census and staff**

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Consistent Assignment: Implementation Issues

Making the math work

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An Option for Scheduling
4 on 2 off schedule

With an Even # of CNA assignments,
3 CNAs serve 2 resident assignments

	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S
Maria	1	1	1	1	O	O	1	1	1	1	O	O	1	1
Jen	2	2	O	O	2	2	2	2	O	O	2	2	2	2
Ellie	O	O	2	2	1	1	O	O	2	2	1	1	O	O

David Farrell

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An Option for Hiring and Scheduling for Dedicated Assignments

- Each 8 hour shift x 7 days = 56 hours
- 56 hours of CNAs = 32 hours + 24 hours
- Hire into 32 hr or 24 hr positions by assignment, alternating weekends
- CNAs can switch days
- CNAs can pick up extra shifts on their neighborhood/household/unit

Resident Assignments	32 hrs Days	24 hrs Days	32 hrs PMs	24 hrs PMs	32 hrs. nights	24 hrs. nights
Group One	CNA 1	CNA 2	CNA 3	CNA 4	CNA 5	CNA 6
Group Two	CNA 7	CNA 8	CNA 9	CNA 10	CNA 11	CNA 12
Group Three	CNA 13	CNA 14	CNA 15	CNA 16	CNA 17	CNA 18

Connie McDonald

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Consistent Assignment: Implementation Issues

How do you handle Burn-out, especially due to:
Hard to care for residents/families

Tip: Team care

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Consistent Assignment: Implementation Issues

Unscheduled Absences

Tip:
Don't double the disruption
All Hands on Deck

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Who are the CNAs?

- Total 1.47 million
- Deliver 80% of hands-on care
- 90% are women
- 51% are non-white
- Average age is 38
- 50% are near or below the poverty line
- 41% rely on public benefits

GAO, 2001
National Clearinghouse on the Direct care Workforce, 2006
BLS 2006, FHCEF 2010

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From Absenteeism to Attendance

- Data:
  - How many unscheduled absences?
  - How many shifts worked with fewer than scheduled number of staff?
  - How many fill-ins at what cost?
    - Agency?
    - Overtime?
    - Unfamiliar with work area?
    - Is today's fill-in tomorrow's call-off?

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Measure It - Collect Data

- Single point person
- Review individual records monthly
- Analyze it for individual's and facility trends
  - By day of the week
  - By unit, shift
- Feedback – one of three letters in paychecks
  - Thanks for good attendance
  - Come see us if you need help
  - We need to talk to you about your poor attendance

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Perfect Attendance Bonus

- Time Period
- Amount
- Pay-out options:
  - Lump sum
  - Increase the hourly rate for next pay period
  - Non-monetary (gas cards, grocery cards)
  - Raffle
- Team rewards

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Proactive Replacement Plan

Short term:

- Call employee who called off
  - Show concern
  - Replace for next shift?
- Replacement priority list
  - Confirmed to come in
  - Name, phone number
  - Best time to call

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If Working Short Staffed

All hands on deck

- **Managers assist on the floor**
- Housekeepers pass trays and make beds
- Dietary staff pass trays, pick up trays, pass water pitchers
- D.O.N. and Nurse managers complete some treatments

Your assistance today prevents tomorrow's absence

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Scheduling Success

- Increase FT and decrease PRN and PT
- Hire reliable people
- Schedule –
  - Consistency, accuracy, predictability
- Attendance intervention
- Flexibility
  - Allow staff to trade days
  - Honor requests for time off

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The "To Do" List

- Measure it
- Fairness, Flexibility, Support and Accountability
- It starts with a good scheduler
- Employee Assistance
- Rewards and recognition – individual and team
- Proactive replacement plan

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Consistent Assignment: Implementation Issues

How to Handle Transitioning
when a CNA leaves

Tips:
Provide a good introduction for resident to new person providing care

Huddles and Teamwork to help new staff get to know residents

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Consistent Assignment: Implementation Issues

Support staff
in their grief when a resident dies

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Take a Break

Studies Show Low Effectiveness and High Danger

- Antipsychotic effect takes 3-7 days to start working
  - Very sedating medication so acute effect is most likely due to sedating effect not the antipsychotic effect

David Gifford, MD, AHCA, 2013

Net effectiveness

"For every 100 patients with dementia treated with an antipsychotic medication, only 9 to 25 will benefit"

Drs Avorn, Choudhry & Fishcher
Harvard Medical School
Dr Scheurer
Medical University of South Carolina

Source: Independent Drug Information Service (IDIS) Restrained Use of antipsychotic medications: rational management of irrationality. 2012

David Gifford, MD, AHCA, 2013

Associated with adverse outcomes

- Off-label use of antipsychotics in nursing facility residents are associated with an increase in:
  - Death (heart failure or pneumonia)
  - Hospitalization
  - Falls & fractures
  - Venothrombolic events (stroke)
- Conventional antipsychotics are worse than atypical antipsychotics

David Gifford, MD, AHCA, 2013

Management of Behavioral and Psychological Symptoms in People with Dementia Living in Care Homes: A UK Perspective

Clive Ballard
Professor of Age Related Diseases,
King's College London
And Director of Research, Alzheimer's Society (UK)

Exploring new directions

Major Adverse Outcomes with antipsychotics over 6-12 weeks

(Schneider et al 2005,Ballard et al 2009)

- Parkinsomism
- Sedation
- Gait disturbance
- Increased respiratory infections
- Oedema
- Accelerated cognitive decline
- Stroke (>3 fold)
- Other thrombo-embolic events
- Mortality (1.5-1.7 fold)

Why do people die?

- Causes of death (Ballard et al 2010)
  - Pneumonia
  - Stroke
  - Pulmonary embolism
  - Sudden cardiac arrhythmias
- Likely Mediating Factors
  - Dehydration
  - Chest infection
  - Over sedation
  - Q-T prolongation

Conclusions – the Evidence Base

- Antipsychotics have a focussed but limited role in the short term management of severe aggression and psychosis.
- but we are currently overprescribing, the longer term efficacy is limited and the serious adverse risks are considerable
- The evidence base supports the value of simple non drug interventions and intensive staff training in care homes

Clive Ballard

FDA Black Box Warning

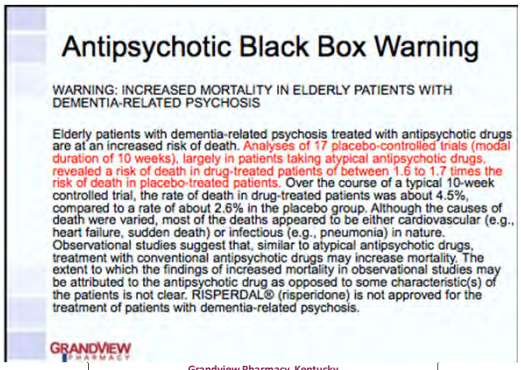
- Issued in 2005
- Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis
  - Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. [Name of Antipsychotic] is not approved for the treatment of patients with dementia-related psychosis.

WARNING

Increased Mortality in Elderly Patients with Dementia-Related Psychosis — Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. [this drug] is not approved for the treatment of patients with dementia-related psychosis.

David Gifford, MD, AHCA, 2013

Survey Guidelines - *F 329 and Antipsychotics*


Antipsychotic Black Box Warning

WARNING: INCREASED MORTALITY IN ELDERLY PATIENTS WITH DEMENTIA-RELATED PSYCHOSIS

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. RISPERDAL® (risperidone) is not approved for the treatment of patients with dementia-related psychosis.

GRANDVIEW PHARMACY

Grandview Pharmacy, Kentucky

Can you stop antipsychotics safely?

If individuals with dementia on low dose antipsychotics were randomized to either continue their meds or abruptly switched to a placebo, would the placebo group's behaviors compared to continued meds group be?

a. a lot worse
b. somewhat worse
c. **no different**
d. somewhat better
e. a lot better

David Gifford, MD, AHCA, 2013

Making Sure Everyone's Included in the Process

Sharing the Work of Staff at

Sea View Hospital Rehabilitation Center & Home

Staten Island, New York
New York City Health and Hospitals Corporation

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Debrief on the video

Communication Systems – the QAPI Infrastructure that makes improvement stick

At Sea View they use communication systems to include everyone in the process every day

What communication systems do they have in place that contribute to their QAPI success?

What ideas does this give you?

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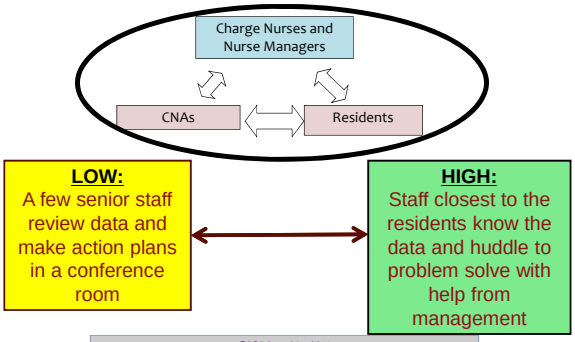
Relational Coordination in Daily Huddles Supports Teamwork for QAPI



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QI Rounds
Huddle With Staff Closest to the Resident

- Bring the white board
- Write down all the ideas
- Prompt people
- "No blame"
- Set rules
- Enhance problem solving competence
- Stay with it

David Farrell 2014

QI Rounds Huddle Questions

- What are possible causes?
- What causes can you do something about?
- What's the easiest to change that has a big impact?
- What help do you need?
- How will you know it worked?
- Who do you need to involve?

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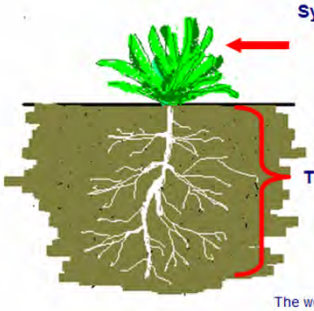
Root Cause Analysis Basics



Symptom of the problem.
"The Weed"
Above the surface
(obvious)

The Underlying Causes
"The Root"
Below the surface
(not obvious)

The word root, in root cause analysis, refers to the underlying causes, not the one cause.

Root Cause Analysis

- Structured way of looking at events from a systems perspective
  - Events are rarely just the fault of one person doing the wrong thing
  - People operate in a system. The system can make it easier for them to do the right thing, or more difficult
  - Have to look at multiple contributing factors
  - If you don't uncover all potential causes, the event can happen again

Principles

All behavior has meaning
Not just symptoms

All behavior communicates

All behavior expresses unmet
core human needs

Easier to change ours than others

From Susan Wehry, MD

What causes residents':

agitation?

aggression?

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What interventions
can you/do you use
to ***address and prevent***:
agitation?
aggression?

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Change our language

Instead of
"Behavior"…
(to be stopped)

Expression of Need
(to be understood and met)

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Beware of "redirecting"

It's like

Reality orientation…

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To Reduce Off-Label Use of Anti-psychotics:

1. Understand that behaviors are often distress signals communicating **unmet needs**

2. Have systems to know residents well, understand what they are communicating, and problem-solve to **prevent distress**

3. Follow residents' **customary routines**

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Questioning Our Assumptions:

Scenarios

Pair up:

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Imagine…

You have to get to the bus stop at 3:00 to pick up your son. You know he's waiting for you and he'll be upset and crying if you're not there on time. But as you go to try to meet the bus, a stranger stops you and tells you you can't do this and bars you from leaving.

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How Would You Feel?

What Would You Do?

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Imagine…

You are in a deep sleep but you hear someone come into your room. It's someone you don't recognize. They tell you to get up.

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How Would You Feel?

What Would You Do?

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Challenge is changing attitude

- Many health care professionals and families believe that these behaviors are "abnormal", are caused by the dementia, and need medications to stop
- Most health care professionals and families believe these medications are effective at stopping these "abnormal behaviors"

David Gifford, MD, AHCA, 2013

Dementia re-examined

What are actions by individuals with dementia?

Abnormal behaviors
OR
Predictable human responses
to the situation perceived

David Gifford, MD, AHCA, 2013

Distressed Behaviors can seem random, but when we journal them, we start to see patterns and start to connect the dots to the triggers and unmet needs

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Understanding Behavioral Communication

Differentiating Between Agitation and Aggression

Susan Wehry, MD
http://www.susanwehrymd.com

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Agitation

- Slapping thighs
- Clapping
- Yelling
- Screaming

- Self-referred
  - Something is wrong with *me*
  - Do something!

From Susan Wehry, MD

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Agitation

HELP ME
Pain
Hunger or Thirst
Other Urgent Need

From Susan Wehry, MD

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Aggression

- Hitting out
- Kicking
- Pinching
- Biting
- Threatening
- Swearing

From Susan Wehry, MD

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Aggression

OTHER - REFERRED

FEAR - BASED

From Susan Wehry, MD

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Aggression

STOP

LEAVE ME ALONE!

From Susan Wehry, MD

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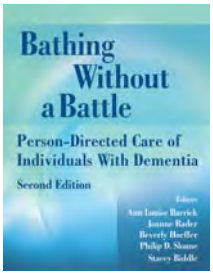

Joanne Rader

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What happened here?

What was the resident communicating?

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What happened here?

What was the resident communicating?

What would an anti-psychotic do?

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What happened here?

What was the resident communicating?
What would an anti-psychotic do?
What would be *effective*
non-pharmacologic interventions?

SHARE

What are you doing to ease the distress of the bathing experience?

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Bathing without Distress

- Timing – night whirlpools…
- Type of wash up
- Who does it
- How it's done
- Journey to the shower room – sit in a shower chair
- Environment – does it look like a storage area?
- Temperature
- Place to change
- Modesty – full size towels
- Self care
- No means no; how can I make you comfortable?

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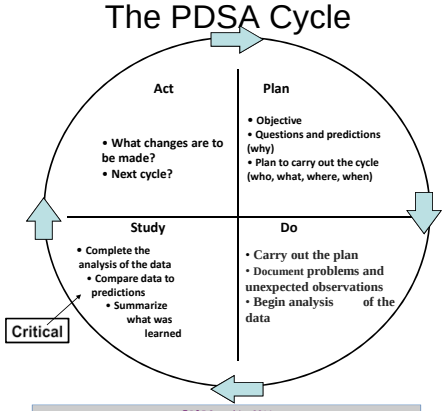
www.cms-handinhandtoolkit.info

The PDSA Cycle



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Process (QI Closest to the Resident):

- See it from the resident's perspective
- Get more information:
  - Clinical indicators/assessment
  - From family, from social history
  - From observation and sharing - diarying to notice triggers
  - Gather all the information you already have
- Look at what interventions work:
  - When someone "works their magic," what is it they do that works?
  - Observation and sharing among staff closest to resident
- Try it
  - Get all disciplines involved
  - What can you alter to make resident more comfortable?

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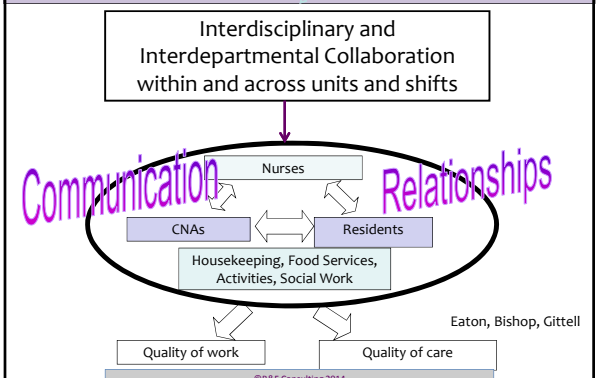
The *Process* Produces the Outcome

Sometimes transformation requires no outside control – when people are given the space to open up, they often unravel their own problems and solutions become clear in the process.

Stephen R. Covey

David Farrell 2013

Relationships Closest to the Resident Matter Most



Eaton, Bishop, Gittell

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Pioneer Network Incubator

Step One – Foundational Practices for Accelerated Improvement

- Consistent Assignment
- Huddles
- CNA Involvement in Care Planning
- QI Closest to the Resident

Step Two – Clinical Applications

- Reduced Falls, Alarms, Antipsychotics, Pressure Ulcers, and Rehospitalizations

Step Three – Individualized Care

- From exception to organization-wide

Toolkit with tip sheets, starter exercises, and media clips at:

www.PioneerNetwork.net

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