Session #: T30

Dementia and Person Centered Care

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Objectives:

Upon completion of this presentation, attendees will be able to:

1. *Learn the latest CMS requirements for BPSD (Behavioral and Psychological Symptoms of Dementia)*
2. *Identify how your staff is currently providing person-centered care.*
3. *Apply QAPI to develop an effective PIP (Performance Improvement Project) to implement Person Centered Care*

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Regulations

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F309: Quality of Care

"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care."

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F309: Quality of Care

If there is no improvement OR if there is a decline, the survey team is directed to:

- Determine if it is avoidable or unavoidable
  - Is there an accurate assessment?
  - Is the Care Plan based on a comprehensive assessment?
  - Is the Care Plan implemented consistently?
  - Are you evaluating the results of the interventions and updating/revising the Care Plan as necessary?

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F309

How can we keep our resident's at their "highest practicable physical, mental, and psychosocial well-being"?

- Comprehensive assessment
- Identification of individualized needs
- Care Plan
  - Development of individualized, measureable and realistic goals and interventions
  - Consistent implementation of interventions
- Evaluation and Revisions
- Ongoing oversight for quality

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Care of the Resident With Dementia

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F309 Care of the Resident with Dementia

1. Definitions and overview
2. Therapeutic Interventions or Approaches
3. Medication Use
4. Resident and/or Family Involvement
5. Care Process
6. Staffing and Staff Training
7. Medical Team Involvement
8. Monitoring and Follow Up
9. Quality Assessment and Assurance

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Definitions and Overview

- Behavioral Interventions
- PCC or Person-Centered or Person-Appropriate Care
- BPSD (Behavioral or Psychological Symptoms of Dementia
- Behavior
- Dementia
- Delirium

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BPSD

CMS Definition:

"Behavioral or Psychological Symptoms of Dementia (BPSD) is a term used to describe behavior or other symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. The term "behaviors" is more general and may encompass BPSD or responses by individuals to a situation, the environment or efforts to communicate an unmet need."

-CMS State Operations Manual, Appendix PP

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Therapeutic Interventions or Approaches

What can we do for success?

- Consistent Assignment
- Root Cause Analysis to identify the reasons for the behaviors
- Staff education on potential causes and prevention
- Appropriate, resident centered activities based on comprehensive assessment

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Medication Use

- Need to follow F329
- Based on Comprehensive Assessment
- What is the rationale?
- Was a good root cause analysis completed to determine reason?
- What alternatives have been attempted and the results?
- Black Box warnings

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Resident and/or Family Involvement

- What evidence exists regarding resident and/or family involvement in the care process?
- How do you involve families?
  - History
  - Resident Refusals
  - Non-pharmacological interventions
  - Input in goals and approaches
  - Medical conditions that could be causing behaviors? (i.e. pain)

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Care Process-F309

The process for the IDT includes:

1. Recognition and Assessment
2. Cause Identification and Diagnosis
3. Care Plan Development
4. Individualized Approaches and Treatment
5. Monitoring, Follow-up and Oversight
6. Quality Assessment and Assurance (QAA)

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Assessment Process

PREADMISSION:

- History and Physical
- Diagnoses
- Prior Living Arrangements and Support
- Psychological Services
- Specific Behaviors and Management
- Violent Behaviors?
- Restraint Use
- Medication History (what has been used and changes)
- Psychological and Cognitive Testing
- Family/Responsible Party Contact

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Assessment Process

- Admission:
  - History
  - Medications
  - Medical Conditions (delirium, dementia, etc.)
  - Preferences (food, exercise, routines, etc.)
  - Behaviors (Are they unsafe or dangerous behaviors?)
  - Non-pharmacological interventions attempted
  - Family/Resident input

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Assessment Process

- MDS (MDS 3.0 RAI Manual Chapter 3)
  - Section E: Behavior
    - Intent:
      - To identify behavior symptoms (7 days) that may cause distress to the resident or distressing or disruptive to the other residents, staff or facility.
      - The behaviors could put the resident at risk for injury, isolation and activity.
      - To identify possible unrecognized needs, preferences or illness
      - To identify frequency and impact of behaviors in order to determine which behaviors are problematic
      - To develop an individualized care plan
      - Focuses on actions, not the intent of the behavior

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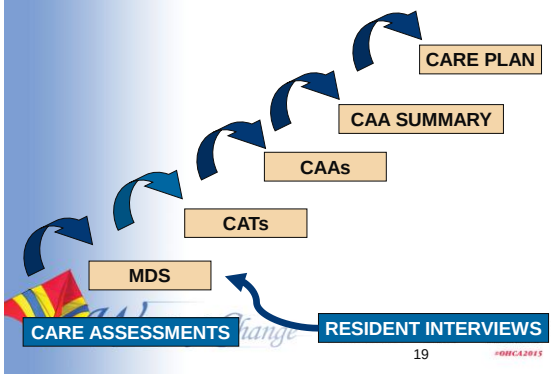
RAI PROCESS



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Identification

- Resident Diagnosis
- New Medical Conditions or Behaviors
- Notifications
- What could be causing the behaviors?
  - -RCA investigation?
  - -Is there an environment change?
  - -New roommate?
  - -New medication?
  - -New care giver?

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Care Planning

- Individualized based on comprehensive assessment
- Person Centered
- Addresses baseline
- Outlines target behaviors
- Measureable, realistic and individualized goals
- Individualized approaches
- Resident refusals
- Medications (indications for use, target behaviors, expected outcomes, dosage, duration, specific monitoring and GDR)
- Non-pharmacological interventions

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F309 addresses F329:

Medication Use in Dementia:

"It has been a common practice to use various types of psychopharmacological medications in nursing homes to try to address behavioral or psychological symptoms of dementia (BPSD) without first determining whether there is an underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental cause of the behaviors"

**State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Rev. 02-06-15

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F309 addresses F329

- When Antipsychotic meds are used without adequate reason OR when used only to limit or control behaviors:
  - There is little chance of effectiveness
  - There are common complications
  - There is an increased Risk for Death

**The FDA issued a Black Box Warning for Atypical Antipsychotics in Dementia indicating an increased risk of death:
http://www.fda.gov/Drugs/default.htm

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F329

Unnecessary Drugs:

- An unnecessary Drug is a drug that is used:
  - In excessive dose (including duplicate therapy)
  - For excessive duration
  - Without adequate monitoring
  - Without adequate indications for its use
  - In the presence of adverse consequences which indicate the dose should be reduced or discontinued
  - Any combination of the above

F329

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F329: Unnecessary Drugs

Antipsychotic Medications:

- Indications for Use
  - Conditions Other than Dementia
  - BPSD
  - Criteria
  - Dosage
  - Monitoring
  - Effectiveness
  - Potential Adverse Consequences

- Deficiency Categorization

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F329

- Monitoring
- Effectiveness
- Adverse Consequences
- Documentation

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F329: Medication Management

- Selection of Medications based on individualized need, benefits and risks
- Evaluation and Assessment of effectiveness and adverse consequences
- Meds to be used in proper dose and appropriate duration based on assessed need of the resident
- Non-pharmacological approaches should be utilized based on comprehensive assessment to reduce the need for medications
- Monitoring

**State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Rev. 02-06-15

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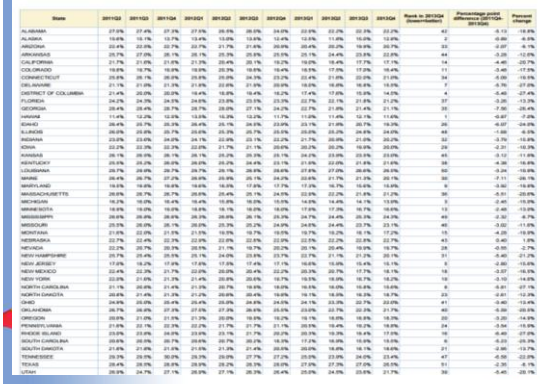
Gradual Dose Reductions-F329

Antipsychotic Medications:

"Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated."

**State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Rev. 02-06-15

Figure 3: Quarterly Prevalence of Antipsychotic Use for Long-Stay Residents, States 2011Q2 to 2013Q4



OHIO's Numbers

Figure 3: Quarterly Prevalence of Antipsychotic Use for Long-Stay Residents, States 2011Q2 to 2013Q4

State	2011Q2	2011Q3	2011Q4	2012Q1	2012Q2	2012Q3	2012Q4	2013Q1	2013Q2	2013Q3	2013Q4	Rank in 2013Q4 (lower=better)	Percentage point difference (2011Q4-2013Q4)	Percent change
OHIO	24.9%	25.0%	25.4%	25.4%	25.0%	24.8%	24.5%	24.1%	23.3%	22.7%	22.0%	41	-3.40	-13.4%

Report on the CMS National Partnership to Improve Dementia Care in Nursing Homes: Q4 2-11-Q1 2014, Karen Tritz, Director, CMS Division of Nursing Homes, Michele Laughman, CMS Health Insurance Specialist, Alice Bonnor, CMS Consultant, Northeastern University. April 1, 2014

Steps Necessary to Ensure Adequate Comprehensive Assessments Lead to Person-Centered Care

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Collaboration *WITH* the Resident and Family

- **It takes**
  - planning!
  - It takes a bit of time!
  - It takes a little digging!
  - It takes patience!
  - It takes *creativity*!

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Let's Look at Our Processes

Where does a good amount of our information come from for the initial care plan?

The Admission Process

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Admission Assessment

- What are the nurses doing on that Friday pm when many of the residents are admitted?
  - Passing medications
  - Treatments
  - Processing orders that came back after the day shift left
  - Calling practitioners for updates
  - Assessment follow up, documentation, etc……

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Admission Care Plans

- Who completes them?
  - Friday pm or weekend admissions
  - 24 Hour Care Plan?
- Where is the information derived?
- How is this communicated?

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Are WE MISSING a Piece of the Puzzle?

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Traditional vs. Person-Centered

Traditional

- Staff directed
- Medical/Diagnosis based
- Staff goals
- Therapy goals
- **Based on assessments when resident's admitted to the facility

Person-Centered

- Resident directed
- Preferences (choice)
- Habits
- Routines
- History of Medical Management
- The *resident's* understanding of medical management of conditions
- Resident's goals

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Care Plan Essentials

- Based on the Comprehensive Assessment
- Based on Resident Choice and Preferences
- Individualized
- Goals that are realistic, measureable and make sense to the resident!
- Approaches: Unique to the resident needs that assist the resident in achieving the goal!
- Consistently Implemented
- Evaluation Process/Revisions as Necessary

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Putting it all TOGETHER

- Where are the preferences/choices/habits of the resident documented:
  - Nursing Notes
  - Social Service Notes
  - Activity/Recreational Therapy Notes
  - Dietary Notes

******How do we put it all together??***

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Taking the TIME…

- To sort through the information and identify the individualized needs and wishes of each resident
- What is *THEIR* perception?
- Asking, "What would YOU like to see differently?

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Resources

- Advancing Excellence in America's Nursing Homes
- Pioneer Network
- The Green House Project
- Eden Alternative
- And More!

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Remember the Nursing Process

- Assessment
- Plan
- Implementation
- Evaluation and Follow-up

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QAPI

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Definitions

- QAPI: Quality Assurance and Performance Improvement: "the merger of two complementary approaches to quality management"
  - QAPI News Brief, Volume 1/2013, pg. 1

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QAPI

QA – Quality Assurance (F520 QA&A, Quality assessment & assurance)

- Identifies and corrects quality issues
- Retrospective
- Focus on outliers or individuals
- Efforts end once achieved
- DON, Physician and 3 staff members
- Meet quarterly

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Performance Improvement

PI - Performance Improvement

- Proactive approach
- Efforts are on-going
- Focus on system changes
- Plan involves input from staff representing all roles and disciplines within the organization
- Meet at more frequent intervals

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QA is already in our SNF

Because quality assurance is already in place in your nursing home, the added emphasis is on Performance Improvement

They compliment each other and are both key in successful outcomes

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- QAPI is resident-centered yet built on systems thinking.
- QAPI involves everyone who works in your facility.

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Elements for QAPI in SNFs

- Systemic Analysis and Systemic Action
- Performance Improvement Projects
- Feedback data systems and Monitoring
- Design and Scope
- Governance and Leadership

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5 Elements

- You can find the detailed descriptions of the 5 elements on the CMS website:

http://cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/fiveelementsqapi.pdf

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QAPI Applies Structure to Process

Performance Improvement Plans (PIP's) are essentially care plans that allow you to set Person Centered Care in motion.

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Element: Performance Improvement Projects as the Key to Success!

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Performance Improvement Projects (PIPs)

- Conduct (PIPs) in areas needing attention for the purpose of *improvement*;
- Identify priority areas for PIPs appropriate to the nursing home's scope (high risk, high volume, problem-prone areas)
- Establish teams in order to develop a specific focus
- Gather data, study, institute improvement changes, re-evaluate, make adjustments—keep the pattern moving!
- Report PIP findings to leadership and the team for both communication of process and further action

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Team is Full of I's!

- Representation from all departments
- All roles involved in the work being improved
- Recruit enthusiastic members who are invested in the PIP topic.

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PIP-Working It Out!

When Person Centered Care is not fully implemented:

- Individualized needs are not met
- Increased potential for negative outcome

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PIP-Working It Out

When staff are not using a good RCA (root cause analysis) process:

- Care Plans are not individualized and do not identify accurate concerns or potential successful interventions

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We need a PIP Team!

- To teach all staff person-centered dementia care
- To ensure care plans are individualized vs. generic
- To ensure the resident and family is included in process
- For individualized discharge planning

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Performance Improvement Projects

- Help you organize the plan!
  - WHAT-is the problem statement?
  - WHY-Root Cause Analysis
  - WHERE (do you want to go) – Goal
  - HOW- Interventions based on RCA

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Methods for Success

- Team members meet at designated time intervals (i.e. every 2 weeks on Tuesday at 10:00-10:45am)
- Role of each member is clearly stated
  - Audits
  - Staff Education
  - Care Plan Recommendations
  - Documentation
- Documentation of team meeting results
- Goals and Plan for next meeting

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AUDIT-Example

Area of Review	YES	NO	Recommended Action	Staff Responsible/Date
Care Area Assessment includes input from the resident and/or family				
There is evidence that the care plan includes documented preferences and choices of the resident and/or family				
The Care Plan (and C.N.A. Care Record) includes specific, individualized goals and interventions based on the comprehensive assessment				
There is evidence of Care Plan updates based on resident changes				
Care Plan interventions are implemented upon observation				

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AUDIT-Example

Area of Review	YES	NO	Recommended Action	Staff Responsible/Date
Documentation is present in the resident record, of attempts to manage behaviors with non-pharmacological interventions for residents using antipsychotic medications prior to the use of medications?				
Gradual dose reductions are attempted for residents in accordance with F329				
Medications are used within the manufacturer's recommended timeframes, stop date or duration (unless documentation exists for clinical justification for continued use)				
There is documentation of evidence for monitoring for effectiveness and adverse consequences				

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Action Plans

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Action Plan

Area for Correction	Plan	Date Due	Responsible Party
Care plan does not contain specific individualized information from the CAA	1. Education will be provided for all IDT members involved in CAA and care planning process. 2. All care plans will be reviewed and updated with individualized goals and interventions with next MDS cycle 3. Audits will be completed weekly to monitor compliance 4. Results of audits will be addressed in the Quarterly QA Committee Meeting	5/15/15 Starting 5/15/15 for 3 months Starting 6/1/15 7/1/15	DON or Designee DON or Designee IDT Team DON or Designee
C.N.A. Care Record not updated with current care plan information	1. Education will be provided for all IDT members involved in care planning to update C.N.A. Care Record 2. All C.N.A. Care Records will be cross-referenced/updated with Care Plans	5/15/15 Starting 5/15/15 for 3 months Starting 6/1/15	DON or Designee DON or Designee IDT Team

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GREAT Resource

- CMS: Review of Care and Services for a Resident with Dementia
  - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QIS-Dementia-Care-Checklist.pdf

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Checklist

Review of Care and Services for a Resident with Dementia

(for use with the Interpretive Guidance at F309)

Assessment and Underlying Cause Identification

- ✓ Did staff describe behavior (onset, duration, intensity, possible precipitating events or environmental triggers, etc.) and related factors (appearance, alertness, etc.) in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?
- ✓ If the behaviors represent a sudden change or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation, as appropriate?
- ✓ If medical causes are ruled out, did staff attempt to establish other root causes of the behavior using individualized knowledge about the person and when possible, information from the resident, family, previous caregivers and/or direct care staff?
- ✓ As part of the comprehensive assessment did facility staff evaluate:
  - The resident's usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  - How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration?
  - Prior life patterns and preferences customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?
- ✓ Did staff, in collaboration with the practitioner, identify risk and causal/contributing factors for behaviors, such as:
  - Presence of co-existing medical or psychiatric conditions, or decline in cognitive function?
  - Adverse consequences related to the resident's current medications?

1. ***If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident's behavioral and/or mental psychosocial symptoms, and needed adaptations, and the impact upon the resident's function, mood and cognition?***
   If No, cite F272

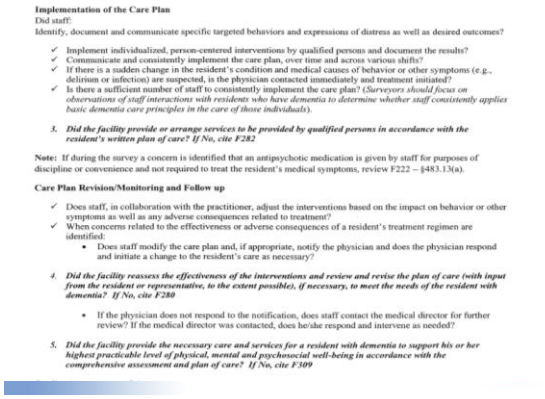
1. ***If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the physical, mental and psychosocial needs of the resident with dementia to identify the risks and/or to determine underlying causes (to the extent possible) of the resident's behavioral and/or mental psychosocial symptoms, and needed adaptations, and the impact upon the resident's function, mood and cognition?***
   If No, cite F272

Care Planning

- ✓ Was the resident and/or family/representative involved (to the extent possible) in discussions about the potential use of any interventions, and was this documented in the medical record?
- ✓ Does the care plan reflect an individualized team approach with measureable goals, timetables and specific interventions for the management of behavioral and psychological symptoms?
- ✓ Does the care plan include:
  - Involvement of the resident/representative to the extent possible?
  - A description of and how to prevent targeted behaviors?
  - Why behaviors should be prevented or otherwise addressed (e.g., severely distressing to resident)?
  - Monitoring of the effectiveness of any/all interventions?
- ✓ If the resident or family/representative refused a recommended treatment or approach, was counseling on consequences and alternative approaches to address behavioral symptoms provided?

Note: If the resident lacks decisional capacity and lacks effective family/representative support, contact the facility social worker to determine what type of social services or referrals have been attempted to assist the resident.

2. ***Did the facility develop a plan of care with measurable goals and interventions to address the care and treatment for a resident with dementia related to the behavioral and/or mental/psychosocial symptoms, in accordance with the assessment, resident's wishes and current standards of practice? If No, cite F279***



Implementation of the Care Plan
Did staff:
Identify, document and communicate specific targeted behaviors and expressions of distress as well as desired outcomes?

- ✓ Implement individualized, person-centered interventions by qualified persons and document the results?
- ✓ Communicate and consistently implement the care plan, over time and across various shifts?
- ✓ If there is a sudden change in the resident's condition and medical causes of behavior or other symptoms (e.g., delirium or infection) are suspected, is the physician contacted immediately and treatment initiated?
- ✓ Is there a sufficient number of staff to consistently implement the care plan? (*Surveyors should focus on observations of staff interactions with residents who have dementia to determine whether staff consistently applies basic dementia care principles in the care of those individuals*).

3. ***Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care? If No, cite F282***

Note: If during the survey a concern is identified that an antipsychotic medication is given by staff for purposes of discipline or convenience and not required to treat the resident's medical symptoms, review F222 – §483.13(a).

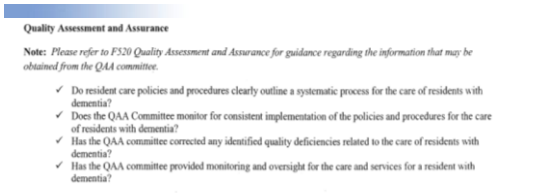
Care Plan Revision/Monitoring and Follow up

- ✓ Does staff, in collaboration with the practitioner, adjust the interventions based on the impact on behavior or other symptoms as well as any adverse consequences related to treatment?
- ✓ When concerns related to the effectiveness or adverse consequences of a resident's treatment regimen are identified:
  - Does staff modify the care plan and, if appropriate, notify the physician and does the physician respond and initiate a change to the resident's care as necessary?

4. ***Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident with dementia? If No, cite F280***

  - If the physician does not respond to the notification, does staff contact the medical director for further review? If the medical director was contacted, does he/she respond and intervene as needed?

5. ***Did the facility provide the necessary care and services for a resident with dementia to support his or her highest practicable level of physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care? If No, cite F309***

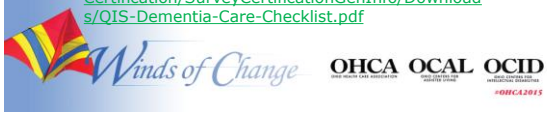


Quality Assessment and Assurance

Note: *Please refer to F520 Quality Assessment and Assurance for guidance regarding the information that may be obtained from the QAA committee.*

- ✓ Do resident care policies and procedures clearly outline a systematic process for the care of residents with dementia?
- ✓ Does the QAA Committee monitor for consistent implementation of the policies and procedures for the care of residents with dementia?
- ✓ Has the QAA committee corrected any identified quality deficiencies related to the care of residents with dementia?
- ✓ Has the QAA committee provided monitoring and oversight for the care and services for a resident with dementia?

- CMS: Review of Care and Services for a Resident with Dementia
  - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QIS-Dementia-Care-Checklist.pdf



References and Resources

- State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities, Rev. 02-06-15
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
- CMS: Review of Care and Services for a Resident with Dementia
  - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QIS-Dementia-Care-Checklist.pdf

Resources

- Interim report on the CMS National Partnership to Improve Dementia Care in Nursing Homes:
- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-19.pdf

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Resources

QAPI News Brief Volume1, 2013:

- http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/QAPINewsBrief.pdf
- http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

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Person-Centered Care Resources

- https://www.nhqualitycampaign.org/goalDetail.aspx?g=PCC
- https://www.pioneernetwork.net/CultureChange/
- http://thegreenhouseproject.org/
- http://www.edenalt.com/
- http://www.polisherresearchinstitute.org/#!assessment-instruments/c16rg

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Questions

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Thank You!

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QAPI ACTION PLAN

Location:	**Date:**	**Team Members** **ADM** **DON** **SS** **UM** **CNA**

Concern

Person Centered Care needed to improve quality of life for residents with dementia.

Root Cause Analysis:

1. ***Staff cannot describe PCC or demonstrate process***
   - ***PCC process is not included in orientation, on-going education or daily huddles***
2. ***Care plans are not individualized (are interventions & updates easily accessible?)***
   - ***Generic care plans are more convenient than texting in individualized interventions***
3. ***Resident/Family not included in care plan development***
   - ***'Decline to participate' related to inconvenient on-site, conference calls or other means of input not suggested***
4. ***Individualized Discharge Planning only initiated on admission or revised as needed for short-stay residents***
   - **No one assigned to complete on long-term residents, lack of focus**

Goals & Objectives

Person Centered Care in place in 100% of care plans by July 1
All new admissions starting May 15 2015
Updated current care plans at quarterly review or sooner

Action Items (corresponding to Root Cause Analysis)	**Responsible Team Member(s)**	**Start Date**	**Estimated Completion Date**	**Actual Completion Date**	**Comments**
1. Educate staff in PCC principles and rationales - Add to orientation materials - Add PCC review agenda item to daily huddles - Attend huddles and interview staff to reinforce					

QAPI ACTION PLAN

2. Initiate PCC worksheet Review in shift huddles Add worksheet items to care plans at clinical review meetings					
3. Include Resident/Family in care plan development - Offer to reschedule to convenient time - Include through telephone conference - Discuss & ask for input over phone - Hold conference in room convenient to resident					
4. Assign staff to initiate and complete discharge planning for long-term residents					