Organization: Hebrew Home of Greater Washington (The Charles E. Smith Life Communities)

The Hebrew Home provides post-acute services and long-term care to a daily average census of 500 residents. The Home is located on a 34-acre campus in Rockville, Maryland.

Solution Title: Improving the Safety of Dementia Care by Reducing the Use of Antipsychotic Medication in the Long-Term Care Setting

Program/Project Description, including Goals:

What is this project? Antipsychotic medications help suppress psychotic symptoms in individuals with schizophrenia. While these medications can help some people with dementia who do have psychosis, frequently the medications are used when a person acts in a way that is challenging or disturbing to others such as hitting, yelling, screaming, refusing care, walking around, crying, banging, or throwing things. Antipsychotic medications can be harmful though, in this vulnerable population causing significant side effects. Many elderly individuals are admitted to the Hebrew Home already prescribed these medications by their primary care physicians. Individuals suffering from dementia deserve better than merely to be given these drugs as a first line of choice.

The Hebrew Home has embraced the notion that no resident should be prescribed an antipsychotic medication without an assessment for the underlying cause of the behavior it seeks to minimize. Consistent with its mission and core values, clinical leaders at the Hebrew Home of Greater Washington identified this opportunity to improve the safety of dementia care by reducing its use of antipsychotic medications as a priority quality initiative.

Progress was determined by monitoring two sets of outcomes: first, the monthly assessment of anti-psychotic utilization percentage throughout 2014; and second, the 2014 Maryland HealthCare Commission Family Satisfaction Survey results. These results were also examined to look at rating of Autonomy and Resident Rights, Overall Rating of Care, and Whether families would recommend the Hebrew Home to others compared to the Maryland State averages for over 200 nursing home facilities.

Why is this project important? Antipsychotic medications can be dangerous when used in the elderly population. Some of these side effects include cardiac conduction disturbances, sedation, anticholinergic reactions, stroke, parkinsonian events, cognitive slowing, tardive dyskinesia, orthostatic hypotension, earlier death, and reduced bone mineral density. In addition, this group of medications is expensive to consumers and Medicare, costing billions of dollars (more than $13 billion in 2007 and $7.6 billion in 2011). The literature confirms that there is a high prevalence of antipsychotic medication use in nursing home residents, especially in residents with a diagnosis of dementia. Moreover, daily dosing often exceeds recommended levels and includes inappropriate indications (Briesacher, 2005). A correlation has also been drawn between the likelihood of a resident to receive an antipsychotic medication with facility-level
antipsychotic prescribing rates, even after adjustment has been made for clinical and socio-demographic characteristics (Chen et al., 2010).

Who embraced this project? This project was led by an interdisciplinary team which worked together throughout the year to improve the safety of dementia care by reducing the use of antipsychotic medication in the geriatric population receiving long-term care. The team consisted of:

1. VP of Quality and Corporate Compliance
2. Director of Nursing
3. Medical Staff
4. Performance Improvement Managers
5. Recreation Therapy
6. Social Work
7. Pharmacist Consultant
8. Consultant Psychiatrist

The team’s goal was to reduce the use of antipsychotic medications by turning to effective and safe non-pharmacological, behavioral approaches to the care of residents with dementia. Antipsychotic medications could be considered for residents with dementia, but only after medical, physical, functional, psychological, emotional, psychiatric, social and environmental causes had been identified and addressed.

Process: The team approached this performance improvement project from the perspective of the three “Rs” of Rethinking, Reconnecting, Restoring within the Plan • Do • Study • Act Quality Model framework:

1. **Rethinking our approach to dementia care:** Transforming the culture to rethink the care team’s approach to dementia care. This involved engagement of all stakeholders with daily discussion at the Stand-up meetings between the care team, monthly discussion at the Quality Assurance/Performance Improvement Meetings and quarterly discussion at the Quality Improvement Committee of the Board.

2. **Reconnecting with residents through person-centered care practices:** Incorporating a comprehensive team-based approach to provide care. This was accomplished by starting with new employee orientation, including education on person-centered care scenarios. All employees also participated in mandatory dementia education (8 hours for clinical staff and 2 hours for non-clinical staff).

3. **Restoring good health and quality of life:** Supporting a safe and optimal quality of life by introducing a person-centered approach, assessing triggers for behavior changes, introducing behavioral interventions (e.g. walking with resident, massage therapy, provision of snacks), restricting anti-psychotic medication as a last resort.

Solution:
1. **Engagement of Quality leadership.** In order to succeed, the team prioritized the need to reduce the use of anti-psychotic medication. Strong support was offered by the Board of Governor’s Quality Improvement Committee and Executive Leadership.

2. **Provision of Mandatory Dementia Education to all employees.** One of the first steps was to re-focus the care team and ancillary staff on person-centered care, prevention of abuse, and the need to customize individualized approaches to care of persons with dementia. Mandatory 8-hour dementia education was provided to all clinical staff and mandatory 2-hour dementia education was provided to all non-clinical staff.

The primary components of the dementia education included, but were not limited to the following:

a. **Introduction to Dementia**

   Understanding cognitive impairment and mental illness, the normal aging process, the conditions affecting cognitive impairment and mental illness, the clinical definition of dementia and how it impacts behavior, communication and basic needs; it also included a discussion of how to develop a realistic approach to dealing with people who have cognitive impairment as well as understanding that depression can be mistaken for dementia.

b. **Medical Considerations Related to the Care of Persons with Dementia**

   This component included recognition of reversible causes of dementia, different types of dementia, prevalence in nursing home settings, diagnostic criteria, physical exam for arriving at a diagnosis, tests for dementia, non-verbal pain recognition in dementia, and discussion of competence and capacity within the framework of a dementia diagnosis.

c. **Making Activities Meaningful for Our Residents**

   The coursework also covered developing an understanding of the important role that activity programs play in the day-to-day life of those residents with dementia.

d. **Communication, Behavior and De-Escalation**

   Finally, the program concluded with discussion of the behavioral symptoms found within dementia, causes and reactions---what they can signal, developing care based on principles of person-centered care, developing awareness of the verbal and non-verbal message, reality orientation vs. validation therapy approach, and interventions grounded in understanding these principles.
3. **A Systematic Process was defined.** The following approach was provided for each resident:

   a. Identify the resident’s behavioral expression of distress, including the nature, frequency, severity, and duration and the risks of those behaviors and discussion of potential underlying causes with the care team and family.

   b. Exclude potentially remediable causes of behaviors such as delirium, infection or other medication) and determine if symptoms are severe, distressing, or risky enough to adversely affect the safety of residents.

   c. Identify environments and other approaches that attempt to understand and address behavior as a form of communication and in persons with dementia, and modify the environment and daily routines to meet the person’s needs.

   d. Assess the effects of any intervention (pharmacological or non-pharmacological); identify benefits and complications in a timely fashion; adjust treatment accordingly.

   e. Use gradual dose reduction (team approach including the clinical pharmacist, attending physician, and clinical team manager) to transition a resident off the medication.

   f. All residents admitted on an antipsychotic medication were re-evaluated at the time of admission and/or within two weeks of admission to consider a reduction in dose or discontinuation.

4. **Discussion of findings** at daily Stand-up meeting between members of the care team. The Stand-up meeting occurs daily at 8:30 a.m. in the Social Hall of either the Wasserman or Smith-Kogod Residence. The 24-hour summary report within the electronic medical record (Point Click Care or “PCC”) is projected on a large screen for all attendees to view. The interdisciplinary team discusses all reported behaviors and potential interventions as well as ongoing status of other interventions already in place. The team learned that many of the residents’ actions were indicating that they needed something such as needing a nap because they were tired, fluids because they were thirsty, food because they were hungry, activity or change in environment because they were bored, and/or a visit to the bathroom because they needed to urinate.

5. **Review of project status** at monthly Quality Assurance/Performance Improvement (“QAPI”) meetings, quarterly Board of Governors Quality Improvement Committee meetings, and quarterly Pharmacy and Therapeutics Committee. Monthly stats regarding the percentage of residents on anti-psychotic medication and the gradual dose reduction report from the consultant pharmacist was reviewed.
**Measurable Outcomes:** The measures used reflect two separate outcomes (both described below). The first, percentage utilization, takes into account all antipsychotics; the common medications including Haldol, Quetiapine (Seroquel), Olanzapine (Zyprexa), Aripiprazole (Abilify), and Risperidone (Risperidal).

The second outcome measurement includes three measures from the Maryland Health Care Commission (MHCC) Survey. This survey measures the family or responsible party’s experience and satisfaction regarding care of the resident at the nursing home. The team examined the Hebrew Home’s performance in three different areas as noted below: the score for Autonomy and Residents Rights (0-4 scale), the Overall Rating of Care (0-10 scale), and the Overall percentage of parties who would recommend the Hebrew Home to others (0-100% scale) compared to the State average scores.

1. **Measure:** Percentage of Long Stay Residents who are receiving antipsychotic medication per month
   **Description of Measure:** Percentage of long stay residents (>100 cumulative days in the nursing facility) who are receiving antipsychotic medication.

2. **Measure:** MHCC Survey score for Autonomy and Resident Rights
   **Description of Measure** Two questions were asked of the respondents and scores were calculated by averaging the responses for each question across all respondents for that facility survey. This resulted in a score averaged from 1 = never to 4 = always. The two questions focused on privacy during visits with clergy or family as well as privacy during the care of the resident such as showering, bathing, dressing. This all reflects content of education received during the mandatory dementia education.

3. **Measure:** MHCC Survey score for Overall Rating of Care
   **Description of Measure:** The respondents were asked to rate the care of the resident received at the nursing home on a scale of 1 to 10, “1” being the worst possible care and “10” being the best possible care.

4. **Measure:** MHCC score for Percentage of families who would recommend facility to others
   **Description of Measure:** This measure reflects the percentage of respondents answering “Definitely yes” or "Probably yes” to whether they would recommend the nursing facility to others.

**Sustainability:** To date, the following practices continue to sustain the improvement:

1. The pharmacist consultant generates a gradual dose reduction report which is sent to the VP of Quality and Corporate Compliance. That report is then disseminated to each Performance Improvement Manager overseeing quality improvement within the 14 nursing units at the Hebrew Home. The report helps the Performance Improvement
Manger and Nurse Manager of each unit to gauge the unit’s progress as well as identify which residents are currently prescribed an anti-psychotic medication;

2. Monthly and quarterly review of progress at the QAPI and QIC meetings, respectively;

3. The behavioral assessment tool has been built into the electronic medical record, Point Click Care (“PCC”) so that the use of the tool is used routinely as part of continuous nursing care. Staff identifies and document specific target behaviors, expressions of distress and desired outcomes. Individualized, person-centered interventions are implemented and documented. The care plan of these interventions is communicated throughout all shifts establishing continuity of care.

4. Education regarding (1) use of the behavioral assessment tool; and (2) person-centered approaches to care is included in the new nursing employee orientation;

5. Mandatory Dementia Education (8 hours for clinical staff, 2 hours for non-clinical staff) with annual re-education.

**Role of Collaboration and Leadership:** As noted above, team engagement was critical to the success of this improvement effort. The Board and Executive Leadership’s support were both strong and supportive from the initial start-up of the project.

**Innovation:** Several Innovative approaches contributed to the success of this improvement:

1. Collaboration between multiple disciplines (quality, nursing, medical, pharmacy, behavioral health)

2. Monthly audits of all residents currently prescribed a routine and/or anti-psychotic medication

3. Monthly audits of all residents undergoing gradual dose reduction of antipsychotic medication

4. Board involvement (Board’s Quality Improvement Committee)

5. Monthly (and Quarterly) progress reports using measurement graphics

6. Incorporating a behavioral assessment tool into the electronic medical record

7. Discussion of behavioral issues at daily Stand-up Meeting led by Director of Nursing and attended by Nurse Managers, Performance Improvement Managers, Social Work, Recreation Therapy, and Medical Staff
Related Tools and Resources:

1. Measurement Graphs (see below)
2. Behavior Assessment Tool

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The Hebrew Home of Greater Washington
Anti-Psychotic Medication
Utilization Rates 2014

- National Average = 22.8%
- Regional Average = 21.1%
- Maryland Average = 19.2%

Currently at 11.8%

The Maryland HealthCare Commission Family Satisfaction Survey 2014

Rating (0-4) for Autonomy and Resident Rights

[Bar chart showing Maryland State Average and Hebrew Home comparison with a score of 3.8]
The Maryland Healthcare Commission Family Satisfaction Survey 2014

Rating (0-10) for Overall Rating of Care

Rating for overall care
- Maryland State Average
- Hebrew Home

The Maryland Healthcare Commission Family Satisfaction Survey 2014

Rating (0-100%) for Recommending the Hebrew Home to other Families

Rating for recommending
- Maryland State Average
- Hebrew Home
Behavior Monitoring Pathway Tool

Charles E. Smith Life Communities

(1) Care team member (nursing, therapy, activities, medical) witnesses new behavior:
- Wandering
- Poor self-care
- Restlessness
- Inattention or indifference to surroundings
- Impaired memory
- Mild anxiety
- Sadness or crying alone
- Fidgeting
- Nervousness
- Insomnia
- Uncooperativeness

(2) Care team member initiates documentation in PCC
Description of behavior
When did it happen?
Where did it happen?

Was onset sudden? (check for underlying medical condition, e.g. UTI)
Is there a safety concern? (implement safety strategy)
Is care team member distressed? Offer education needs, stress reduction strategies

(3) Establish underlying cause
Was there a trigger?