Scenario 1

The Issue:
Your nursing home, Green Acres, received deficiencies in F309 and F329 during the annual survey because its residents reflected pattern-use of antipsychotic medications as a first-step treatment intervention for traditional dementia "behavior" symptoms. Green Acres failed to identify non-pharmacologic, person-centered care approaches prior to using antipsychotic medications to properly care for the affected residents.

What Green Acres Did:
The facility's Quality Assurance (QA) Committee developed a Plan of Correction (POC), which contained the following components:

- Implementing an antipsychotic medication gradual-dose reduction (GDR) plan for the affected residents.
- Conducting a chart audit of all residents with dementia to ensure no other residents are affected by the deficient practice.
- In-servicing the Nursing Department (licensed nurses) on appropriate vs. inappropriate requests to attending physicians for antipsychotic medications.
- Conducting three monthly audits of medication administration records (MARs) of residents with dementia to ensure compliance.
- Reporting audit results to the QA Committee.

The director of nursing (DON) or designee will monitor the above areas for compliance. The POC was accepted by the State Survey Agency.

Scenario 2

The Issue:
During the monthly Quality Assurance & Performance Improvement (QAPI) meeting at Green Acres, staff members discovered an increased trend of long-stay residents on antipsychotic medications over the last three months, as documented in the **CASPER MDS 3.0 Reports**. During the discussion, a licensed vocational nurse (LVN) in charge of the facility's nursing department noted that there had been a spike in antipsychotic medication use in the Memory (i.e., dementia) Care Unit (MCU). In response, the QAPI Committee decided to launch a **Performance Improvement Project (PIP)** on the increased use of antipsychotic medications because this trend posed a high-risk, quality-of-life problem for residents. Furthermore, the QAPI Committee set a Specific, Measureable, Attainable, Relevant, Time-bound (**SMART) Goal** for antipsychotic medication reduction for the unit.

What Green Acres Did:
The QAPI Committee chartered a PIP Team composed of a certified nursing assistant (CNA), the LVN charge nurse, social worker, activity director, and nurse practitioner—all associated with the MCU. The team studied the issue by performing **a Root Cause Analysis (RCA)** to generate a **Plan of Action**. The RCA revealed several underlying factors, including:

- Traditional activities designed for alert-and-oriented-nursing home residents were being performed on the MCU.
- There was a high number of resident falls on the unit.
- Staff members on the unit reported an increase of resident "behaviors," including poor safety awareness, agitation, crying or yelling out loud, and "hallucinations."
- No system existed to ensure resident preferences were honored.
- Staff members did not understand how to provide validation-orientation for nursing home residents with dementia.

Based on the identified underlying causes, the PIP Team recommended these interventions:

- Have the MCU staff members visit a local best-practice nursing home specializing in dementia care. They will learn to complete bio sketches on new residents during advanced-care planning meetings with immediate family members to tailor person-centered care activities, referencing the residents' daily routines.
- Help staff members learn to view resident "behaviors" as "needs-driven expressions." This understanding will help staff members realize that the "behaviors" are ways residents with dementia communicate unmet physical or psychosocial needs.
- Have staff members on the MCU create "life stations" based on the bio sketches of the collective resident population, reflecting typical life situations. One life station can be designed as a "laundry room," while another can be a "maintenance shop." The life stations compliment the validation-orientation training of the facility's direct-care staff members.
- Have the nursing home administrator and DON enlist the help of the facility's medical director to educate its practitioners on the Food and Drug Administration's black-box warnings regarding antipsychotic medication use for persons with dementia, as well as the above person-centered care approaches recently implemented at Green Acres.
- Review all physician order requests for antipsychotic medications by the DON prior to presenting to the attending physician.
- Have all physician orders, new admission charts, incident reports, and 24-hour reports reviewed daily by the Interdisciplinary Team following the director's stand-up meeting.

The interventions were implemented in the MCU that was home to 25 residents. The PIP Team collected data from the CASPER MDS 3.0 Reports, the MARs, 24-hour reports, and daily CNA meetings.

After three months, the MCU staff members found that eight residents were able to discontinue use of their prescribed antipsychotic medication(s) through gradual-dose reduction. In addition, five residents who were scheduled to receive antipsychotic medications due to exhibited "behaviors" ultimately did not receive them because of the changes in resident policies.

Green Acres decided to adopt and expand the changes to other areas of the facility **using PDSA: Plan-Do-Study-Act cycles**. The facility received no deficiencies in F309 and F329 on its annual survey. Using QAPI allowed staff members at Green Acres the opportunity to identify and correct developing issues before they escalated to larger problems.

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