Challenges

Systems

Staffing

What's in it for me

Vicious cycle

Change is hard

Institutional Nihilism

Alignment of financial incentives

Safety vs. Quality of Life – not in conflict, not a balance – false dichotomy

Fear of regulations – so short term fix versus critical thinking and nursing practice; lack of options and lack of systems to solve a problem

Declining state support

Dementia – people who can't advocates for themselves and are not understood

Dementia frightens us and caregivers so medication gives a false sense of security

Over-medicalization of dementia – labels that make them medical problems instead of understanding what's actually going on

Hard for quantify – fuzzy

Preference-based trials

Environment – social and physical

Iatrogenic affect of iatrogenesis

Blanket rules

High injury rates for staff – false belief – myth regulations

Family involvement – don't know what else can be done

Observation and interpretation – what's it communicating – why's it happening? Lack of root cause analysis

Misunderstanding of effect of meds – use for a limited time because it's a short term context of the agitation and because the adverse affects are so great – never looked at again

Consistent assignment, huddles, care team

Statement of deficiencies – and plans of correction not effective – chorus of unintended complacency – subtle context

F Tag 329 – has all the right questions – what else have you tried and regularly reviewed? But if MD writes a 329-compliant order, it won't be questioned – a cocoon, not a spiderweb – make a silk scarf

Family education – including family in care plan process – not at odds but seen as a resource – and not deference

Survey for outcome tags and then go to process if the outcomes warrant

How unravel the cocoon and get the person back to themselves?

What should training look like?

The facts about iatrogenic effect of medications:

Law and Evidence-based:

At best, modestly effective and often harmful; non-pharm individualized does benefit without harm

NH can do with same staff

What does a good process look like?

Multi-determined and individually expressed – not one right intervention – where's the root cause analysis

Tie in with QAPI – for any adverse situation, where was the root cause analysis and cause specific intervention

Revised survey process to focus better

Tools – what questions to ask

If you have questions about what you're seeing – here is background information

Root cause analysis

Models of positive outcomes to demonstrate how it could be

Change the default – look at survey protocol – ala restraints; eliminate what isn't an acceptable medical condition – give narrow examples to make clear that it's only under specific circumstances --- and examples of when it's not appropriate

Progression of dementia – hand-in-hand training for CNAs should also be for surveyors

Walk through the IGs with case like McNally

One hour: Needs

1. Facts about meds and about individualized care
2. Narrow uses for meds and examples of not good approaches
3. Explain behavior as expression/communication
4. Examples of good non-pharm interventions and bad ones
5. Case examples applying the IGs and using critical thinking and root cause analysis
6. Examples of statements of deficiencies and plans of correction
7. Behavioral expression/communication
8. Link to customary routines for non-pharm interventions

Wants:

How would you use QAPI?

A basket of interventions – examples of what was tried and can work – a trail of trying

Change package

Examples of a good assessment of root cause – like UTI not a time for anti-psychotic

RI ICP – how do you know residents' routines, how do you make sure caregivers know, how do you actively assist? How do you customize med pass, meals, rehab schedule to work with resident's customary routines?

How surveyors can talk to physicians?

Triggers review -- What % started on Anti-psychotic? What % are on for 90 days or more?

What about withdrawal and apathy? Failure to thrive….

Easy worksheet with prompts – what's the short list of questions?

What are the clinical standards of practice? What's the level of evidence?

Use QAPI citations for lack of a root cause analysis!!!

Few treatment guidelines, non-pharm first except in an emergency, and even then, also use non-pharm along with…

A different way of looking Behavioral interventions??? Psycho-social – explain the concept – look for communication approach not control approach in the nursing home – who's problem is it? Look at what is triggering behavior?

Tie in with customary routines

ICF-ID ed converted from "mal-adaptive behavior" to what is the person trying to say

Lack of understanding about dementia and so misunderstanding a resident's self-protection response as "resistive" --- also unreal expectations of the natural progression of dementia as people's inability to think gets more so

In training, Start low, go slow

First hour: Non-pharm approaches

1. Paradigm shift in default
    a. Establish rationale
    b. Remind of history ala restraints
2. Facts
    a. about drugs
    b. individualized care/ customary routines
3. Case study
    a. Root cause analysis of true causes – analysis of the context
        i. What are contributors to distress
        ii. What are non-pharm options
        iii. Of environment
        iv. Of progression of dementia and of behaviors – who's problem is it
    b. What does good look like?
        i. What are viable approaches?
        ii. Even if severe dementia people can experience a positive quality of life

Mandate an all-in week for training on the Hand-in-Hand videos and other roll-outs

Survey Process Group:

1. What is the science – consequences/harms and standards of practice – why look at this
2. Integrate into current process – not new tasks and worksheets – relate to QAPI
3. Interative process – feedback loop as they try to make it work – a transition into being able to take it on
4. Resource challenges – don't make it longer survey process; and deploy training within budget
5. Skills level of surveyors – from novice to expert

QAPI

1. Enabling surveyors to ask powerful and meaningful questions – through case studies for systems thinking – how collect what data – root cause analysis and underlying causes
2. How to reteach basic principles of QAPI, plans of correction, root cause analysis
3. Ability to have regular small group discussion among surveyors – face time in training – iterative process to get the tools out right – don't spend time on didactic – get people talking to each other

Medication Management

Content: What surveyors struggle with is justification of drug use

Domain:

1. Indication and justification of meds
2. Esp. look at dementia with related behaviors – worksheet for how to look at process

Dose and Duration

1. Rework table 2
2. Thresholds and evidence-base
3. Gradual Dose Reduction – what's the evidence-base? 6 wks/12 wks?
4. Contraindications – too prescriptive

Monitoring and Care Planning

1. What can surveyors ask of providers

2. What is process for monitoring and care planning

Enforcement

1. Integrate into current worksheets
2. What is harm, how determine severity and scope? – psycho-distress; look at people who died
3. Need multi-prong approach to change behaviors

Informed consent/discussion – documentation

Next Steps

1. What resources – and QAPI
2. What did we learn from restraints

How spread

1. All national initiative – all-in week to learn
2. monthly review of cases
3. Use technology – Skype
4. train-the-trainer
5. Sustainable learning and action networks
6. Like restraints – smaller group who takes it all forward consistently
7. How get feedback to surveyors and agencies
8. Get professional/practitioner groups - GNP's, AMDA, ASCP – to help teach/be resources to surveyors or be speaker's bureau – to give the science and evidence base
9. 50 LANEs, with cross over of culture change coalitions – you can target stakeholder groups something to work on, they come together and run with it – intervention was teach the LANEs how to help nursing homes

Link/Evidence of Harm

How strong is correlation/evidence/link between meds and stroke, pneumonia (5x risk); thrombosis (70% increased risk)

Less solid – dehydration and sedation

Application of science to survey process

Surveyors don't cite cause and effect – just what happened; outcome and then process of not assessing and care planning

Second Day recommendations

See it from the perspective of the resident – change frame of reference – resident perspective and a new way of doing things

Not ABC – but vignettes – ***What do you see*** – be a detective – what do you see – not what's causing it?

Active engagement in non-traditional learning – out of language of root cause analysis – change the point of view to resident's point of view – see it differently

Aggression is fear – so how reduce fear

Culture of curiosity and on-going learning – work-based learning – constant huddling

Learned a lot – it's exciting again

Sherlock Holmes role

Must have nots is a check off list – never expansive enough

Good on biological affects for changing medical status but not other environmental stimuli or general psychosocial

Surveyor ask: What was the resident experiencing – did you huddle, what did you learn,

Tell me about the resident – what do they know about her individually

When resident has a Distress signal – what did you understand about it and what did you do?

Paradigm shift – be explicit

Surveyors' job is not to solve the problem – it is to make sure the practitioners do

But yourself in residents' shoes with factors of dementia that have memory loss, and lack of sight or hearing or cognitive experience to be able to recognize what's actually happening – their perception

Do these three things, vs. do them what at a time

So about the life long patterns as well as the disease

So surveyors ask, how does their condition affect their experience?

Iterative process –

Loss – experience of institutional life

Experience of the resident

Fear is the greatest presence in his life

Inexactitude of language – new frame of reference

Agitation – self-referential behavior – screaming – help

Aggression – slap – go away – other-referred behavior - fear

If people who hit are scared, then question is what are they afraid of

First hour

Trust, relationship building – build enthusiasm and adult principles – articulate in first hour that we know how hard it is to change – purpose of first hour is to get second hour.

Limits of science

Experience is best teacher

First ten minutes of first hour – experiential, video, science, and then how-to

Acknowledge expertise of person themselves – they are experts on whether they are comfortable – they have innate abilities that remain with them that we can tap into.

I can't change the way you think, but can change the way you feel – neuronal cascade

What's it like to be in a strange place – and have an impaired thought process

Have surveyors ask mental algorhythm of understanding what's happening

We don't have a randomized trial for parachutes

What can surveyors do – ask providers how they saw resident as expert in what's happening to them

Combination of techniques – PPT of science, videos of case studies and resident experience and best practice

NO PRN Anti-psychotics –

Telephone orders? In an emergency

Differentiate psychosis and dementia – careful because psychosis is not reason for med – important to clarify terms because that's the dialogue happening in deciding on med

What about med techs?

What should CNAs know about what's the problem and what's the intervention? CNA is source of behavior reports that justify the med

Can facility tell you why they were put on med in the first place?

What trying to communicate – what is the reason – not okay reason to say because the resident has dementia

What did you try before you used medication?

How explain to family members?

QAPI –

Will address the systems

QA&A doesn't do it

Systems thinking across the board

Surveyor training re plans of correction – have to address underlying systems – they don't know what they should be looking for

An iterative process

The business case for QAPI – for providers and surveyors

10 min	We've been there before – restraints – and now's a new moment You made a difference, you can do it again – and it was hard, and worth it – it was possible – this is another paradigm shift – for everyone – this is the same start with a typical scenario they see now and say this will help them have a way to respond differently so surveyors are hooked – what regs are we talking about
15 min	What is the shift – what are we seeing differently

	Experiential – exploring the world from a resident's perspective Create the aha moment about the resident experience of dementia/mental health – what is being expressed

15 min	Science of meds and standard of practice/standard of care – on non-pharm because harm of drugs is high and harm of non-pharm is low
15 min	Scenarios – problem solving – and what good looks like – in scenario **ask the questions you'd like the surveyor to ask** – new critical thinking and link to individualized care

5 min	What questions would you ask – tie to regs (329, QL, QAPI)
5 min	Where to go for more info and what's next – more training – come back or go to videos for more scenarios and what good looks like
Future hours	Dementia 101 Science of individualized care and built environments Built environment – what to ask More scenarios – more of what good looks like