Improving Dementia Care & Reducing Unnecessary Use of Antipsychotics: A Process Assessment Crosswalk

This crosswalk is an accompaniment to the Improving Dementia Care & Reducing Unnecessary Antipsychotics Self Assessment created by the Health Quality Innovation Network (HQIN). The crosswalk outlines each of the key areas that need to be addressed in order to successfully reduce the use of unnecessary antipsychotics for people with dementia while overall improving quality of life and care. For each area there are more detailed practice ideas and tools to help with the suggested practice.

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Dementia Care – Policies, Leadership, Training, Documentation: Implementing systems that the facility adequately provides care to residents with Dementia.		
	Practice Ideas	Tools
The facility has specific policies and procedures related to comprehensive care planning. These policies and procedures define how plans are developed that are reflective of resident specific risks, factors, goals, resident centered interventions and are based on each individual's preference and choice.	• Review policies and procedures for a systematic process in providing care of residents with dementia. • The QAA Committee monitors for consistent implementation of the policies and procedures for the care of residents with dementia. • The QAA Committee identifies and corrects identified quality deficiencies related to the care of residents with dementia.	• Facility Assessment • Use Medications Appropriately Probing Questions
Facility has sufficient staff that possess the appropriate competencies and skills to provide direct services to residents with Dementia.	• Use nationally recognized dementia care guidelines or programs as the basis of care for with dementia. • The facility has a designated licensed professional to coordinate dementia care training.(This is currently not a requirement of participation) • All staff (direct care and indirect care) receive dementia care training. • All staff receive dementia care training upon hire, annually, and periodically, as needed. • The facility has documentation confirming the training provided and topics covered. • Staff can articulate what they would do to obtain additional support/skills if they do not know how to implement care plan goals. • The facility looks at ways to systematically structure the care processes around the residents' individual needs and not around staff needs or routines. • The facility's overall philosophy of care acknowledges behaviors as a form of communication and there is an expectation that all staff strive to understand the meaning behind behaviors.	• Facility Assessment • National Nursing Home Quality Improvement Campaign (NNHQIC) Dementia Care Training Crosswalk

Assessing Resident and Individualized Care Planning: Practices to understand who the resident with dementia is and their needs. It is through understanding the individual needs of the resident with dementia that you can understand the meaning of behavior and how to address it.		
	Practice Ideas	Tools
Prior to or at admission facility obtains information from the family/ responsible party on resident preference, routines, social patterns, responses to stress, recent changes in behavior or cognition, cultural preferences, usual cognitive patterns, mood and behavioral distress associated with dementia, how resident typically communicates a need, expectations for how nursing home will work with the resident to prevent and reduce any distress, and effective responses.	• Arrange pre-admission meetings with residents and families to get to know them and guide them on what to expect when they move in. • Review admission process and evaluate whether information needed about the resident is obtained - e.g., who they are and what they need – and if this information is getting to staff. • Practice "conversational assessing" – gathering necessary information in a conversational, natural, relaxed manner in order to build trust and relationships. • Talk with both family members and residents, separately if needed. Residents and family members might provide different information. • Ask residents and family members to create a preferences collage - a visual representation of the things important to a resident, their likes, preferences, etc. • Ask residents and families to create "My Life Story" – a document, album, or book that tells us about a person, including their past history, accomplishments, preferences, etc. (Staff can also help create this with residents and families.) • Utilize questionnaires such as "About Me" and "All About Me" to get to know residents. • Utilize the Preferences for Everyday Living Inventory (PELI) to determine things that are important to residents.	• About Me • Life Story Questionnaire • Long-Term Care Improvement Guide • All About Me (Page 157) • Life History Template (Page 159) • Preferences for Everyday Living Inventory (PELI) • MDS Section F: Preferences for Customary Routines and Activities • A Good Welcome: The First 24-Hours Tip Sheet • Preferences for Everyday Living Tool
The information obtained prior to or during the admission process is made accessible to direct caregivers and support staff.	• Develop a process for sharing what you have learned about a resident with staff. If the information goes directly into a resident's chart, ask whether staff is seeing the information and their ideas for sharing it with others. • Conduct huddles, which are quick team meetings often led by CNAs, as a way to share important resident information. • Ensure care plans are accessible to caregivers. • The facility social worker is contacted to determine what type of social services referrals are indicated if the resident lacks decisional capacity and lacks effective family/ representative support.	• Huddles Tip Sheet • Communication Log/ Notebook for shift-to-shift communication • Resident Cardex

The facility has a system in place to identify changes in resident preference, response to stress, changes in behavior or cognition, and effective response.	• Review how different members of the team report changes in residents. Do all members of the team know to whom they should report changes? Do they know what types of changes they should be aware of? • Involve CNAs in the care plan to ensure that the changes they see in residents are reflected in the care plan. • Implement Quaility Improvement (QI) Huddles. QI huddles are a way to bring staff together to discuss a specific resident and do a root cause analysis of a behavioral expression. QI huddles can happen at any moment, or they can be planned for specific times.	• CNA involvement in care plan • QI Huddles
The facility has a system in place to assist staff members in identifying etiology or predictive factors related to individual behavioral expressions and appropriate responses.	• Train staff to assess or ask questions (as appropriate) to help determine etiology of behavioral expression (i.e., assess pain or ask, are you hungry or thirsty?) • Utilize Stop and Watch. This simple communication system will alert licensed staff to changes in resident condition. • Implement huddles to provide opportunities "on the floor" for staff to share changes and how the resident is responding. This information can then flow through established communication channels (e.g., 24-hour report) so that it is incorporated into the care plan and other types of documentation as needed. • Utilize the Hand in Hand Brainstorming Worksheet to help staff think through the possible reasons for a behavior and how to respond. Understanding the reasons behind behaviors can help predict or prevent them. For example, if staff learns that the reason Mrs. Jones is going into people's rooms at night is because she was a nurse and is doing rounds, they can anticipate this and redirect her to other activities where she can feel useful.	• INTERACT Stop and Watch • Huddles • Hand in Hand Brainstorming Worksheet
Facility practices consistent assignment (same certified nursing assistant to same resident)	• Gain leadership support and involvement of licensed and certified staff from beginning to ensure successful implementation. • Consider trying consistent staffing one neighborhood at a time. • Consider expanding consistent staffing to other staff such as nurses, housekeepers, etc.	• Consistent Staffing Tip Sheet • NNHQIC resources on consistent staffing goals
Review systems to validate that ADL function is promoted.	• Therapy staff (OT, PT and/or SLP) and/or restorative nursing staff screen residents soon after admission, quarterly, and with changes in cognition to determine if services would enable the resident to attain or maintain his or her highest practicable level of functioning.	• Progressive Support for Activities of Daily Living for Persons Living With Dementia

Review for Reduction: Identifying residents to reduce or eliminate antipsychotic medications		
	Practice Ideas	Tools
The nursing home administrator, director of nurses, and other team members as appropriate (i.e., pharmacists, medical director, mental health professional, interdisciplinary team members) review the quality measures and pharmacy reports monthly.	• Compare antipsychotic usage with other quality measures such as pain, pressure ulcers, falls, incontinence, restraints, changes in assistance with ADLs, weight loss, and depressive symptoms. • Review use of other psychotropic medications (and comparing this with trends in antipsychotic usage to see if there is a relationship).	• Casper Reports • Pharmacy Reports
Quarterly, at a minimum, the facility QAPI Committee reviews the quality measures and pharmacy reports with the director of nursing, pharmacy consultant and medical director for purpose of tracking and trending data, including trends among providers, and adverse events.	• Review data quarterly at a minimum during QAPI Committee meeting. • Review and discuss identified trends and patterns. • Discuss underlying causes for decrease or increase in antipsychotic medications. • The consultant pharmacy medical record review includes individual resident trends/patterns in prescribing practices and medication administration, behavior documentation compliance, documentation or non-pharmacological interventions prior to medication administration, and documentation of response to interventions and individual resident recommendations. • The monthly consultant pharmacy report addresses the components of the medical record review and recommendations for improving systemic compliance.	• Casper Reports • Pharmacy Reports
The facility has a "real-time" system in place to monitor, track, trend, and evaluate the use of antipsychotic medication (including PRN medication) to identify residents that may be appropriate for reduction or elimination of antipsychotic medications.	• Flag residents receiving antipsychotics for ongoing review. • Evaluate policies and procedures for how they are being monitored, i.e. who is capturing this information, where is it being captured, what information is captured, how often is it captured, with whom is it shared, how often is it being shared, etc. • Review residents receiving and/or with recommendations for antipsychotic medications weekly during the at-risk meeting.	• NNHQIC Dementia Care and Psychotropic Medication Tracking Tool • HQIN Antipsychotic Reduction: Resident Prioritization Tool

The facility has an established system for monitoring each identified resident's reduction efforts for effectiveness of medication changes and approaches (i.e., weekly behavior meetings, weekly at risk meetings, etc.).	• Conduct a comprehensive review of each resident to evaluate potential causes of behaviors, responses, whether they are effective, additional ideas for responses, and whether medication use is appropriate. • Establish two way communication channels to share with direct caregivers prescribed and/or recommend medications and approaches. Seek feedback on effectiveness of approaches. • The Medical Director reviews the consultant pharmacy reports and takes action as appropriate with attending physicians and interdisciplinary team to include but not limited professional counseling for physicians, policy revisions, and education.	
If a resident is admitted with an order for antipsychotic medication the facility has a system to notify the Interdisciplinary Team and Consulting Pharmacist for review of care plan and physician orders within three days of admission.	• Evaluate policies and procedures for how new residents with orders for antipsychotics are "referred" for review.	• 24-hour report • Pharmacy alert systems
The facility has a communication system in place to alert the Interdisciplinary team to new orders for antipsychotic medication from external providers (i.e., hospice or consulting medical providers).	• Evaluate policies and procedures for sharing information about new orders for antipsychotics from external providers, i.e. who is the lead responsible for sharing information with others, which team members receive information, how do they receive it, etc. • Review new orders during daily start-up meetings	• 24-hour report • Electronic Health Record Alert

The facility has an established protocol for the prescribing of antipsychotic medications that is communicated to attending physicians, consulting medical providers, and consulting medical service providers (i.e., hospice).	• Provide background information to medical providers on the CMS Partnership to Improve Dementia Care and reducing unnecessary antipsychotics. • Develop or review existing policies for prescribing of antipsychotic medications and share with prescribers as well as the whole team. • Actively ask for feedback regarding policies and the overall antipsychotic reduction initiative. Share how you are alternatively responding to behaviors of persons with dementia. • The Medical Director reviews the consultant pharmacy reports and takes action as appropriate with attending physicians and interdisciplinary team to include but not limited professional counseling for physicians, policy revisions, and education.	
If a new prescription for an antipsychotic medication is received the facility has a system to notify the interdisciplinary team and consulting pharmacist for review of care plan and physician orders within three days of receiving the physician orders.	• Evaluate policies, procedures, and tracking mechanisms for new antipsychotic prescriptions, i.e., who notifies others, who should be notified and how. • Review physician orders during daily start-up meeting	• 24-hour report • Pharmacy alert systems
A documented process is in place and utilized when initiating or increasing a dosage of an antipsychotic medication (i.e., decision support algorithm, physician order process, reassessment timeline, etc.).	• Utilize a tracking form that documents start date of medication, medication, dosage, reason for medication, and reassessment date. • Notify nursing leadership ASAP when a new antipsychotic medication order is initiated.	• Algorithm for Treating Behavioral and Psychological Symptoms of Dementia • Antipsychotics in Dementia: Best Practice Guide • NNHQIC Dementia Care and Psychotropic Medication Tracking Tool

Understanding and Responding to Behaviors: Gathering information, exploring reasons behind behavior, and identifying responses		
	Practice Ideas	Tools
Staff in all departments are trained in person-centered care and how to respond effectively to behaviors (i.e., training programs on Quality Improvement Organization (QIO) Program website, CMS Hand in Hand, etc.)	• Interview staff prior to training sessions, for their greatest challenges with behaviors. Use training time as an opportunity to brainstorm these challenges. • Use individual video clips from Hand in Hand to facilitate discussion about particular challenges, such as a resident "wanting to go home". • Reinforce key content from training through brief "stand-up" in-services, mini-in-services, written materials, etc. For example, Pioneer Network's Individualizing Care Video Clip and Staff Exercise.	• DREAM Toolkit • Hand in Hand • Pioneer Network Engaging Staff in individualizing Care • Quality Improvement Organization (QIO)

The facility has resources available and accessible to all staff members to assist in meeting the resident's need as behavior expressions occur (i.e., person-centered activities and interests).	• Utilize the strategy "prepare, prevent, present" found in the CMS Hand in Hand Training Toolkit. For each resident, staff should ask:
	  • How can I prepare for this resident's actions/ behaviors?
	  • How can I prevent this resident's actions/behaviors?
	  • How can I be with this resident in the present when behaviors/actions occur?
	• Discuss as a team each resident's activities and interests that the resident has based on their life history and preferences; identify resources needed to meet the resident's needs through those activities. For example, Mrs. Riley laughs every time she sees babies. Staff will have pictures of babies that they share with her when they see her starting to get upset. Or, Mr. Jacobs seems to find comfort in sanding wood. Outside of scheduled woodworking activities, staff have sandpaper and wood on hand for him. Most importantly, share this information widely amongst staff.
	• Involve leadership in supporting staff in preparing, preventing, being present. Leaders can ask staff how they can support them in preparing, preventing, being present. For example, if Mr. Anderson starts talking about wanting to go home at 4 pm, and Angie, his nurse aide has learned that going for a walk with Mr. Anderson at 3:45 pm keeps him from getting upset, how can leadership support staff in making this happen?
		• About Me
		• Life History Questionnaire

The facility has an established system for identifying and reporting changes in resident condition/ behaviors (i.e., huddles, INTERACT Stop and Watch, etc.).	• Review how different members of the team report changes in residents. Do all members of the team know to whom they should report changes? Do they know what types of changes they should be aware of? • Implement Stop and Watch. Stop and Watch is a simple communication system to alert licensed staff to changes in resident condition. • Encourage CNAs involvement in care plan meetings to ensure that the changes they see in residents are reflected in the care plan. • Implement staff huddles. Huddles provide opportunities "on the floor" for staff to share changes and how residents are responding. This information can then flow through established communication channels (e.g., 24-hour report) so that it is incorporated into the care plan and other types of documentation as needed. • Staff communicates any specific triggers of distress that are of concern, as well as desired outcomes to be monitored among disciplines, across shifts and to direct caregivers.	• INTERACT Stop and Watch • CNA involvement in care plan • Huddles Tip Sheet
The facility has an established system for documenting and monitoring resident behaviors and effectiveness of approaches.	• Assess possible reasons for behavior, including what was happening prior to the behavior and unmet needs. • Provide staff training on how to develop responses to behavior - when staff try to understand what the behavior is telling them about what the resident needs. • The Interdisciplinary team assesses behaviors to determine trends of when behaviors are and are not occurring to determine what are potential triggers and implements resident specific non-pharmacological interventions.	• EDGE Worksheet for Describing Behavior • Strategies for Success with People Who Have Dementia Worksheet • Approved organization behavior tracking and documentation form
Family or responsible party education provided regarding behavioral or psychological symptoms and approaches.	• Schedule a time to meet with family member or responsible party 1:1 either in person or via a teleconference. • Provide family member or responsible party with written education materials.	• Consumer brochure on antipsychotics

The interdisciplinary team, to include certified nursing assistants, and other team members (i.e., housekeepers) along with the family or responsible party are involved in the process of developing and implementing effective, person-specific approaches to address behavioral expressions.	• Facilitate staff being able to have team meetings to brainstorm responses to behaviors (i.e., learning circles are a great way to facilitate staff discussion). • Evaluate systems for how everyone knows the approaches being tried, and how they determine whether they are working, and what they do when they don't work. • Individualize all "non-pharmacological" approaches to persons with dementia in order to meet the unique needs and preferences of the person. For example, one person might love music and the other might find it over stimulating. • The facility has a system in place for identifying and documenting resident specific non-pharmacological interventions as an alternative before administering PRN or scheduled medications.	• Learning Circles • Hand in Hand Brainstorming Worksheet • Nono-Pharmacological Approaches to Address Behaviors • Communication and Alzheimer's • Evidence-Based Nonpharmacological Practices to Address Behavioral and Psychological Symptoms of Dementia
The facility has a system in place to notify the family or responsible party of change in resident condition/behavior, physician orders, and/or approaches.	• Ensure daily and per shift processes are in place to notify the designated responsible party of any change in resident condition/behavior. • Notifying staff need to be prepared to discuss assessment of resident and approaches. • Alternatives other than psychopharmacological medications are discussed with staff and resident or family, with respect to the expression or indication of distress, as well as the engagement in behaviors that appear to be distress-related.	
The facility has a system in place to notify and effectively communicate with the attending physician of any change in resident condition/behavior (i.e., SBAR).	• Prior to notifying physicians of resident changes staff should gather information about the behavior, i.e., what, where, when, how, why. Which includes identifying risk and underlying causes for the resident's expressed or indicated distress or behaviors that appear to be stress related such: presence of co-existing medical or psychiatric conditions, or decline in cognitive function, was delirium considered and ruled out, and consideration of adverse consequences related to the resident's current medications. • When a resident expresses or indicates distress or exhibit behaviors that appear to be distress related, staff describes the specific experience of distress, related factors with enough specific detail of the actual situation to permit underlying cause identification to the extent possible.	• EDGE Worksheet for Describing Behavior

The facility has an arrangement that allows for timely access to mental healthcare (psychiatrist, psychologist, LCSW, etc.) through on-site services or telehealth.	• Establish contracts and/or practice agreements with mental health professionals as needed and appropriate.
	• Review and retain job descriptions for staff mental health professionals to include therapeutic services.
		Kansas
		• Kansas Department for Aging and Disability Services Community Services and Program Commission
		• Kansas Behavioral Science Regulatory Board
		• Kansas Board of Healing Arts – Licensing and Regulatory Board
		• Kansas Department for Aging and Disability Services Commission on Aging
		• Association of Community Mental Health Centers of Kansas
		• Kansas Department for Aging and Disability Services Survey, Certification and Credentialing Commission
		• Kansas Aging and Disability Resource Centers
		• Kansas Nursing Facilities for Mental Health
		• Kansas Behavioral Health Central Office
		  • 785-296-3471
		• Private Psychiatric Hospitals- KDADS Commission
		  • 785-368-6375
		Missouri
		• Missouri Division of Behavioral Health
		• Missouri Department of Health Senior & Disability Services
		• Missouri Division of Developmental Disabilities
		• Missouri Healthcare Workforce Registry and Exchange
		• Community Mental Health Centers
		• Community Mental Health Center Directory
		South Carolina
		• SC Department of Aging, Alzheimer's Resource Coordination Center
		• SC Department of Mental Health
		• Hands on Health SC
		• SC Department of Health and Environmental Control
		• Alzheimer's Association SC Chapter
		Virginia
		• Virginia Department of Health Professions
		• Virginia Department of Behavioral Health and Developmental Services

The facility has established procedures and staff are trained in procedures to address emergency mental health needs [i.e., temporary detainment order (TDO)]	• Training is conducted during new hire orientation.
	• Training is conducted on an annual basis and as needed for staff on all shifts.
	• Create relationships with local community service boards.
		Kansas
		• Kansas Partnership to Improve Dementia Care
		  • Linda Farrar, Convenor lindaf670@gmail.com
		• State Trade Associations
		  • Kansas Health Care Association
		  • 785-267-6003
		  • LeadingAge Kansas
		  • 785-233-7443
		• State Professional Association
		  • Kansas Adult Care Executives
		  • 785-273-4393
		• KFMC Health Improvement Partners
		  • Brenda Groves, LPN, CDP, CADDCT, VP of Corporate Training for the National Council for Certified Dementia Practitioners
		  • 785-271-4150
		  • bgroves@kfmc.org
		Missouri
		• Missouri Division of Behavioral Health
		• Missouri Department of Health Senior & Disability Services
		• Missouri Healthcare Workforce Registry and Exchange
		• Missouri Department of Health Section for Long-Term Care Regulation
		Virginia
		• Virginia Department of Health Professions
		• Virginia Department for Aging and Rehabilitative Services
		• Virginia Association of Community Service Boards, Inc.
		• Virginia Department of Health Licensure and Certification

Care Planning – Developing and implementing measurable goals and approaches to address the care and treatment for residents with dementia.		
	Practice Ideas	Tools
Care Plans reflect a person-centered individualized approach with measurable goals, timetables and specific approaches for supporting the resident with Dementia.	• Assess resident treatment and service needs through the Resident Assessment Instrument (RAI) process. • Care plan includes a description of potential distress triggers and non-pharmacological approaches to implement when distress is expressed or indicated. • Care plan includes why potential triggers should be addressed. • Care plan includes strategies and approaches based on information about the resident's previously stated goals and preferences and knowledge about what has been helpful in supporting the resident when they have become distressed in the past. • Staff communicates and consistently implements the care plan, over time and across various shifts. • CNAs are able to describe care approaches, such as task segmentation and others that are used.	• MDS and Care Assessment Areas • Person-Centered Assessment and Care Planning • Person-Directed Dementia Care Planning
The admission information is integrated into the care plan and revised as the resident's condition and/or needs change.	• Review your process for connecting various sources of information about a resident into the care plan (e.g., MDS, life history, PELI, etc.). Is the information you collected about a resident's preferences, life history, etc. reflected in their care plan? • Evaluate how the information you learn about a resident is shared across departments (e.g., dietary, housekeeping). • Involve CNAs in the care plan process. The CNA is vital to having a two-way flow of information (CNAs getting information from the care plan and giving information about the resident to create and change the care plan as needed). • Bring the residents' plan of care to start-up and at-risk meetings. Update change of condition and interventions appropriately.	• CNA involvement in care plan

The nursing home administrator, director of nurses, and medical provider periodically attend care plan meetings for residents with behavioral or psychological symptoms.	• Involve clinical and operational leaders in care plan meetings. It is vital to hear the perspectives of staff on what they have tried and what has or hasn't been successful. • Practice "rounding with reason" during and outside of care plan meetings by asking staff "Do you have everything you need to meet the needs of your residents?" • Use the care plan meetings to evaluate whether there are trends in "behavior problems" that might be related to organizational policies. For example, if behavioral challenges are related to personal care assistance such as bathing, are staff operating under a real or perceived policy about bathing, i.e. needing to bathe residents even when they don't want to be bathed. • Facilitate efforts to develop a person-centered care planning process that includes individualized strengths and needs and is considered a dynamic document that helps staff learn about a person.	• Person-Centered Assessment and Care Planning • Person-Directed Dementia Care Planning
Interdisciplinary team seeks input for care plan meetings from the medical provider, consultant pharmacist, certified nursing assistants, mental health professional, family or responsible party, and other staff members for residents with behavioral or psychological symptoms.	• Utilize the "All Hands" approach. All Hands approach means that all staff are invited to share input about residents (not necessarily attending the meeting). • Use existing communication channels to gather information from staff about residents, such as staff meetings, huddles, communication logs, etc. • Orient staff to a person-centered care planning process that is individualized to the needs and strengths of the resident, and is focused on quality of care and life outcomes. • The nursing assistant with responsibility for the resident attends care plan meetings and is involved in developing and revising the plan of care. • The medical provider actively participates in the care planning process and documents the specific rationale and/or reason for the medication in addition to the supporting diagnosis.	

The family or responsible party is encouraged to participate in care plan meetings and are involved in determining the goals of care that are consistent with the resident's wishes (facility offers flex scheduling or uses conference calls when in-person attendance is not possible).	• Offer family members or responsible parties alternate care plan meeting dates/times. • Talk to family members or responsible parties before the meeting if they are unable to attend. Highlight key changes, successes, and concerns to ask for their input. Follow up with family after the care plan meeting occurs. • Offer a teleconference meeting to review plan of care. • Family and responsible party involvement is documented in the medical record.	• Care plan schedule

Improvement Plan	
For the next three months, what action plan would you be willing to develop that would assist in improving processes and/ or reducing unnecessary use of antipsychotic medications?	• If you would like to do a comprehensive assessment of your dementia care, here is a tool that might help: • Person-Directed Dementia Care Assessment Tool

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