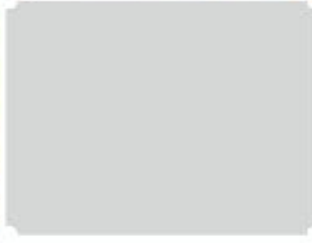
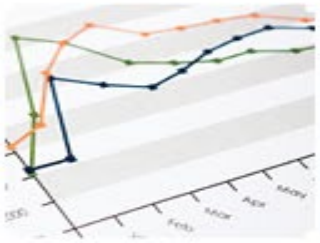
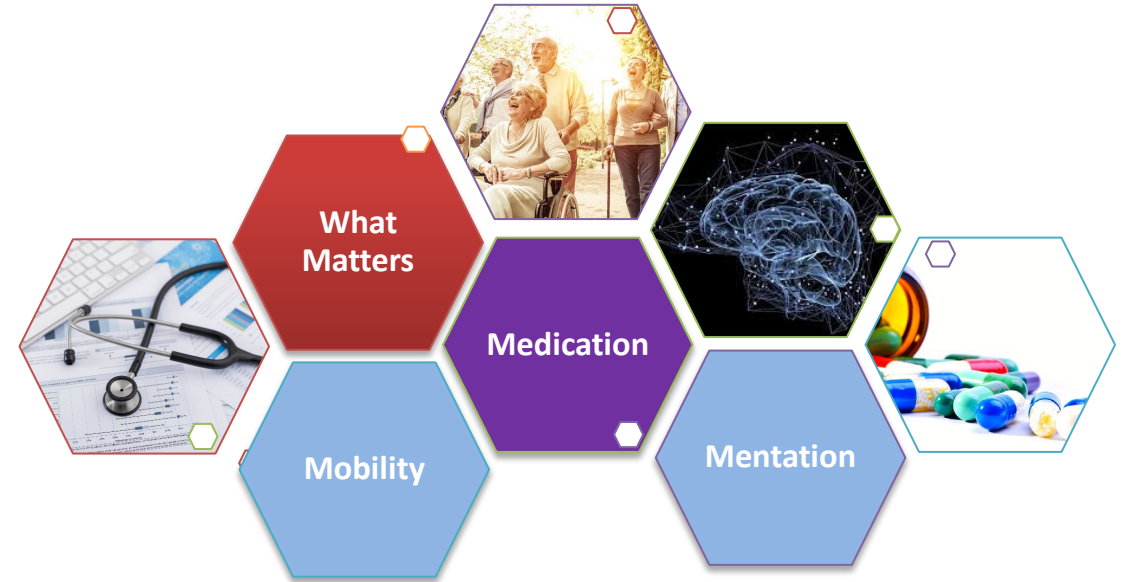


Correlation of Care Using QAPI tools





What can alter
all 4 M's of Age-
Friendly care

- What Matters
- Medication
- Mentation (Mind & Mood)
- Mobility

QAPI – Performance Improvement Project (PIP)

■ PIP team should have the following:

- One person from the QAPI committee - Must be interdisciplinary - No more than 5-6 people (3 if a small) facility
 - Pharmacist , CNA, nurses, Activities, Maintenance, Laundry, etc. (closest to the problem)
 - Consider having residents or families as subject matter experts

■ Leadership support

- Resources, encouragement, available

✓ Clear purpose

- Share the SMART goal with them – Team Charter

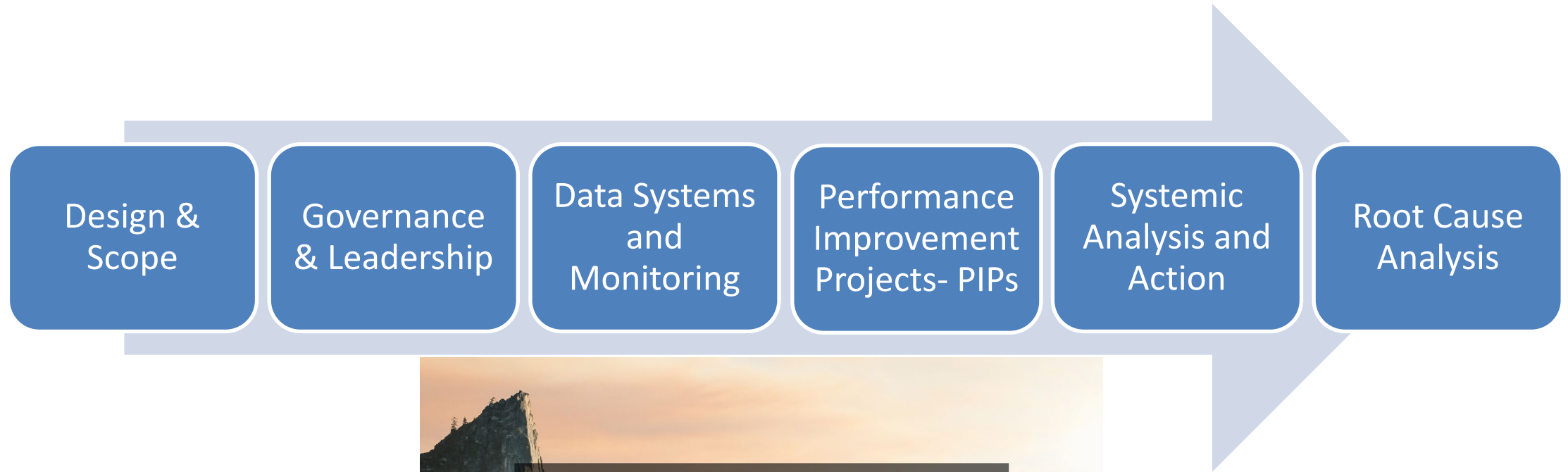
Follow up

Should be meeting frequently, at least weekly
Use Huddles

✓ A plan

- Conduct an RCA
- Help them develop and test a PDSA weekly
- Measurement and data collection daily
- Health Equity

Elements of QAPI



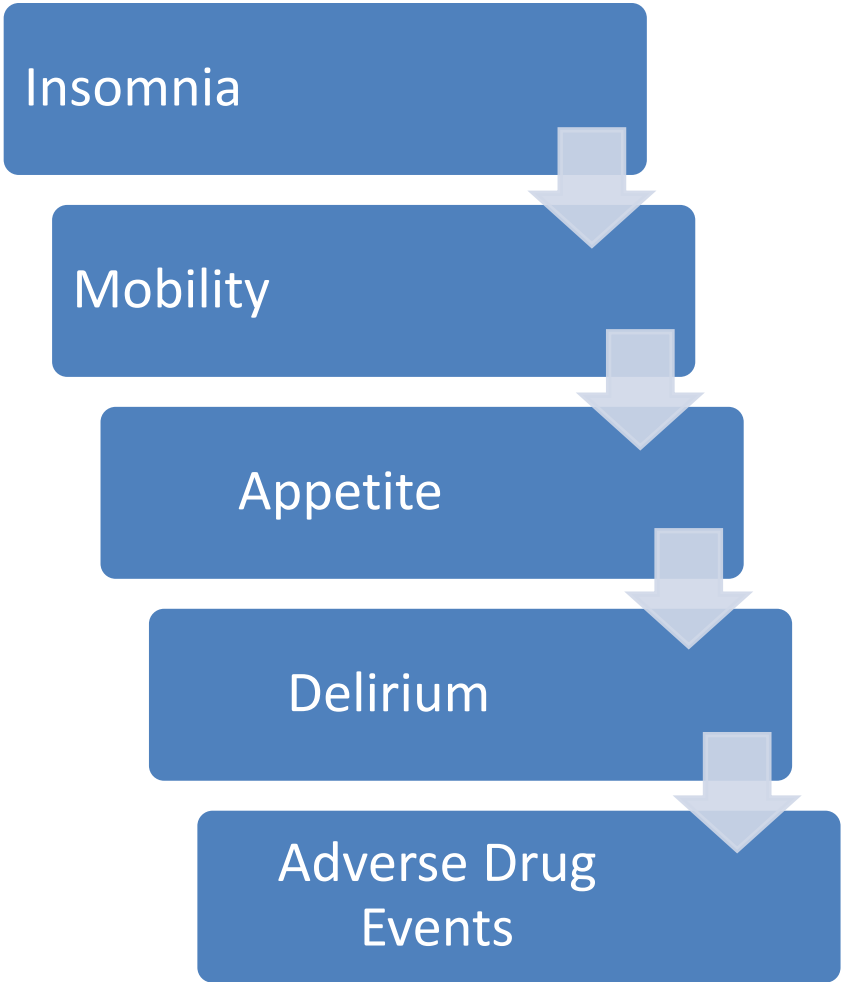
Quality is everyone's
responsibility.

W. Edwards Deming

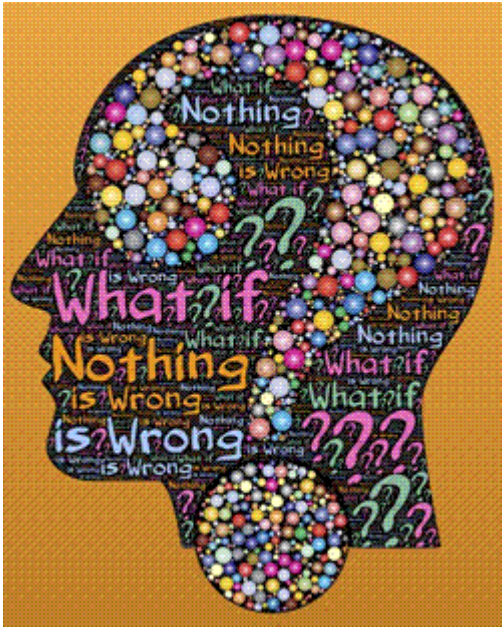
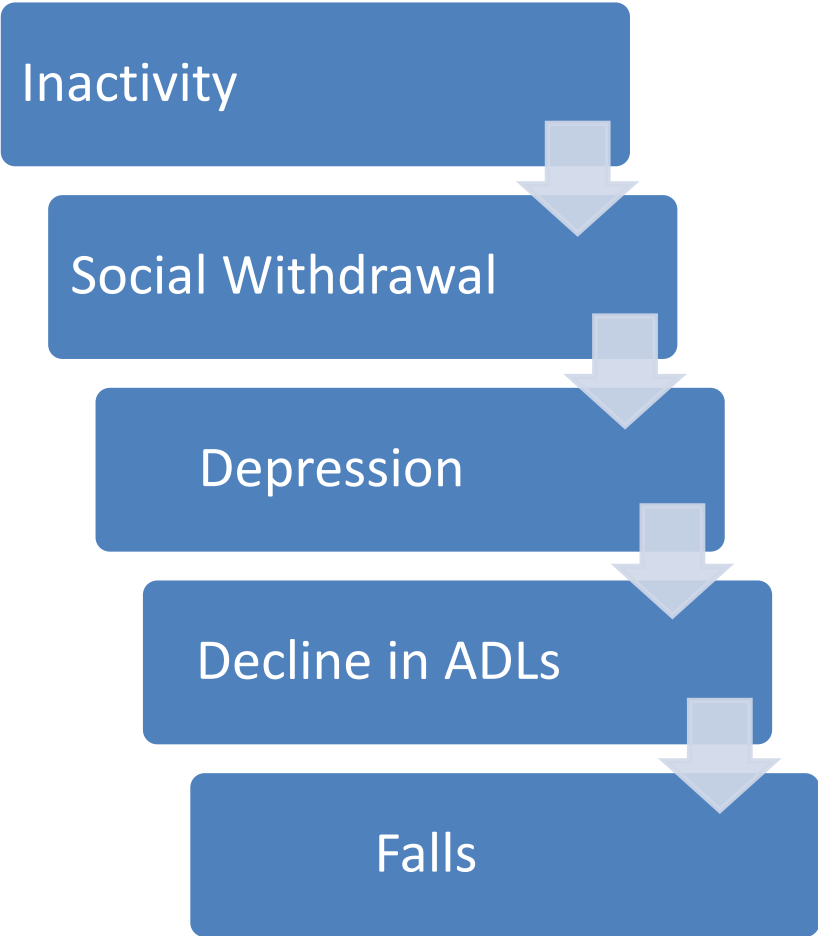
quotechan

Medications can impact a resident’s functional status and quality of life.

Common Medication Side-effects



Effects on Quality



Medication side effects



Manifestations of medication side-effects

- Poor Sleep
- Comfort
- Cognition
- Unstable Balance
- Appetite

Interventions

- Timeline and Root Cause Analysis
- Fewer Meds equals fewer side effects
- Gradual Dose Reduction

Use of Tools

- Comprehensive Assessment Tool
- History
- Health Information Exchange
- Education and Communication Staff and Family
- Narcan for Opioid Adverse Drug Events
- Tapering Tools
- Agreements with Resident and Families

Performance Improvement



- ☐ Falls
- ☐ Effect on Function- ADLs
- ☐ Weight Loss

Interview:

- ☐ Appetite
- ☐ Cognition
- ☐ Nausea
- ☐ Dizziness
- ☐ Intended Resolution
- ☐ Condition Evaluation



Performance Improvement Project (PIP) Documentation

Nursing Home: Comfort Home

Start Date: _____

PIP Team Members:

Staff Name	Title		
	Medical Director		
	DON		
	Pharmacy		
	MDS Nurse		

PIP Team Project:

Quality Measure of Focus	Baseline Rate of QM	Improvement Goal for QM	Goal Rate	Date to reach the goal rate
Antipsychotic Meds	20.1%	Below State Average	10%	Dec 2021

Goal Monitoring:

Current Date	Current Rate	Current Date	Current Rate	Current Date	Current Rate
Nov 2022	16.1%				
Dec 2022	18.2%				
Jan 2023	18.8%				
Feb 2023	13.3%				
Mar 2023	12.9%				

Interventions: The following are the interventions Implemented:

Start Date	Intervention Description	Intervention Notes	Outcome/Results
Nov 2022	Reviewing Antipsychotic Meds rate and Residents triggered on MDS Report-	Identify current resident list and if candidate for GDR; current rate below the state average	Continue to monitor monthly
Dec 2022	PIP team reviewing new admissions for use of Antipsychotic Meds	Identify residents early to determine if candidate for GDR	
Dec 2022	Monitor Timeline of Events for individual residents	Correlate multiple quality concerns	

<https://www.dhs.wisconsin.gov/forms/medbrandname.htm?page=0>

<https://www.dhs.wisconsin.gov/forms/f24277ci-caplyta.pdf>



Informed Medication Consent



- [Medication Informed Consent form](#)

PSYCHOACTIVE MEDICATION THERAPY INFORMED CONSENT FORM

Use a separate form for each medication.

To protect our residents from harm to others and themselves, and to promote our residents for a higher level of independence, it is necessary to use psychoactive medical interventions under certain conditions. Medication interventions are NEVER used for disciplinary action or for the convenience of the facility to control behavior.

Psychoactive medication prescribed for resident _____
is _____ for the diagnosis of _____.

The specific condition(s) being treated include(s):

- | | | |
|--|--|---|
| <input type="checkbox"/> Adjustment Disorder | <input type="checkbox"/> Dementia w/Psychotic Behavior | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Delusions | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual Disorder |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sleeping Disorder |
| <input type="checkbox"/> Catatonia | <input type="checkbox"/> Obsessive Compulsive Behavior | <input type="checkbox"/> Socially Withdrawn |
| <input type="checkbox"/> Combative Behavior | <input type="checkbox"/> Panic | <input type="checkbox"/> Stress Disorder |
| | | <input type="checkbox"/> Other _____ |

The expected benefit(s) from the medical intervention include(s):

- ☐ Improved Functional Ability
☐ Reduced Adverse Behavior
☐ Other (please specify): _____

The clinically significant side effects possibly associated with this medical intervention include but are not limited to:

Antipsychotic	Anti-Anxiety	Hypnotic	Antidepressant	Anti-Manic	Psychomotor Stimulant
Blurred Vision Confusion Constipation Drooling Dry Mouth Involuntary Movements Muscle Rigidity Restlessness Sedation Sleep Disturbances Stiffness of the Neck	Appetite Changes Blurred Vision Constipation Dizziness Drowsiness Fatigue Hypotension Nightmares Sedation Slurred Speech Urinary Retention Dry Mouth	Anxiety Confusion Dizziness Fatigue Hallucinations Headache Lightheadedness Mania Nightmares Sedation Syncope	Appetite Changes Blurred Vision Constipation Dry Mouth Dyspepsia Headache Hypotension Insomnia Weight Changes Urinary Retention	Bradycardia Confusion Drowsiness Hypotension Impaired Cognition Impaired Vision Nausea Nephritic Syndrome Seizures Tremors	Anorexia Dry Mouth Impaired Taste Insomnia Nervousness

The proposed course of therapy is approximately:

- ☐ 1 month ☐ 3 months ☐ 6 months ☐ 12 months ☐ Prolonged treatment/Unknown

☐ I GIVE my full consent for the use of the medication indicated above. I understand that once the targeted behavior is controlled, the usage of the medication should be gradually decreased to the lowest possible dosage and frequency.

☐ I DO NOT GIVE my consent for the use of the medication indicated above. I realize the dangers of not taking this medication may result in uncontrolled behaviors which may make it difficult for the nursing staff to appropriately provide care.

Signature of Resident _____ Date _____

Signature of Representative _____ Date _____

Signature of Person Obtaining Consent _____ Date _____

Verbal Consent given by (full name and relation) _____ Date _____

NAME-Last First Middle Attending Physician Record No. Room/Bed

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BRIGGS Healthcare

PSYCHOACTIVE MEDICATION THERAPY
INFORMED CONSENT FORM

 Oklahoma
Dementia Care
Network

Policy and Procedures focusing on Person Centered Care

- Admission
- Transfer
- Discharge
- Medications (AP and Opioid)
 - Admission process
 - Introduction of new AP meds
 - Specifically state not to be used for sedation
 - Accurate Diagnosis process
 - Resident Rights agree/refuse
 - Informed Consent discussing side-effects
 - Medication Reviews
 - Change in Status Correlation of Care
 - Root Cause Analysis
 - Interdisciplinary Team (Interviews)
- QAPI including Health Equity
- Enhanced Barrier Precautions
- Immunizations including Covid-19
- Medical Director's expanded responsibilities



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