New Reports

CHSRA is releasing two new reports this quarter. The first report is a look at the QIs over time and it will be for all facilities. The ORYX control charts are the other new report and are for ORYX facilities only. The following is a brief description about each of the new reports:

- **Facility Quality Indicator History** has recently been developed for all facilities and is included in your reporting packet for the first time this quarter. It has been printed on yellow paper to help distinguish it from your standard Facility QI reports. This report compares your facility’s QI percentage for this quarter (April 2001 – June 2001) as well as the previous four quarters. The time period for each quarter is identified at the top of the column by the last month in the quarter. The far right column shows the current quarter’s comparison percentage. The previous four quarters of facility QI history should assist facilities in tracking your facility’s QIs over time.

- **ORYX Control Charts** are being provided in compliance with our agreement with JCAHO them to you. These charts portray information useful in interpreting the

(Continued on page 5)
Defining the QI

Residents who have this QI (i.e., are in the numerator) have received an antianxiety or hypnotic medication in the reference period week the Minimum Data Set (MDS) was coded. Since some of the medications used to treat anxiety can also be used as hypnotics (i.e., the benzodiazepines), the term hypnotic is also included. The MDS items, O4b or O4d, are coded as 1 or more. The denominator for the facility includes all residents on the most recent assessment, except those residents with psychotic or related conditions listed in the exclusions. Exclusions include residents with one or more of the following disorders: schizophrenia, Tourette’s, Huntington’s Chorea, hallucinations or those residents with other specified non-organic psychoses. As is true for all QIs, the facility proportion is equal to the numerator divided by the denominator. This QI is not risk adjusted.

Implications of the QI for Your Facility

The report for your own facility gives you some idea of how well you are performing on the use of antianxiety medications in the absence of psychotic or related conditions relative to your comparison group. Depending on your facility, the report may suggest that you are doing better, worse or about the same as your peers. Your response will depend on which of these situations you find yourself in. Clearly, a report that suggests you have more residents receiving an antianxiety medication in the absence of psychotic or related conditions compared to your peers should evoke some action on your part to determine if a problem exists. A report that indicates you have about the same or fewer residents receiving an antianxiety medication in the absence of psychotic or related conditions compared to your peers may also elicit some response on your part. In the following sections, we discuss some of the ways that you may respond to the information. Your goal should be to determine if the medication is necessary. This means, “Is the medication improving or maintaining the resident’s quality of life?” Your second goal is to determine whether the medication’s risk/benefit ratio (i.e., side effects of the medication versus the impact on quality of life of the resident) is appropriate and being monitored.

How should you respond if your facility is not doing as well as its peers?

How should you respond if your facility flags for this QI on a quarterly report, or is consistently above the comparison group proportion? Your first reaction may be to conclude that you have a significant number of residents receiving an antianxiety medication in the absence of psychotic or related conditions, and there is little to be done to change the situation. The information provided by your QI data, especially resident level data, can help you go beyond this first response and seek ways to improve care. Review of QIs, Prevalence of Behavioral Symptoms Affecting Others and Incidence of Cognitive Impairment, on the Facility Quality Indicator Profile report should give you an idea how your facility compares with the comparison group in these areas that can lead to use of antianxiety medications. The Incidence of Cognitive Impairment QI is important because cognitive loss is a major concern with the use of these drugs. Residents who are routinely using antianxiety medications are at risk for developing serious side effects. Unnecessary use of antianxiety medications in the elderly population can be dangerous and may actually worsen behavioral symptoms or decrease quality of life. For example, many antianxiety medications impair cognitive and gait functions, predisposing residents to falls and fractures. Your task is to ensure that all reasonable measures have been pursued for residents in your facility to decrease or eliminate unnecessary use of antianxiety medications. Residents will more than likely require short and long term approaches to decrease anxiety, as listed in the Specific Guide for Antianxiety/Hypnotic Use. Ideally, you may find that there are residents who are likely to improve with alternative treatments, resulting in less medication use. While some conditions do affect the use of antianxiety medications in the absence of psychotic and related conditions, there are numerous non-pharmacological interventions and services that can be provided to both help decrease the use of antianxiety medications in residents with no psychotic and related conditions, and to decrease or eliminate anxious behaviors of residents within the facility.

Following the investigative protocol outlined in the Facility Guide to the Use of Quality Indicators in Long
**QI of the Quarter: Prevalence of Antianxiety/Hypnotic Use Continued**

*Term Care* you can systematically determine whether or not you have a problem in your facility. You begin by choosing a sample of residents from the Resident Level Summary report.

First, you must ensure that there is a “match” between the MDS forms completed for each resident in your sample and the QI definition. Accuracy means that the MDS data is correctly coded on the individual resident MDS, and also that the individual resident MDS accurately reflects the conditions of those residents for the time period reported. This may require talking with residents and facility staff.

To begin, it is necessary to understand the reasons or diagnoses for residents receiving antianxiety medications.

Next, review the care of each resident in your sample to determine whether individual residents have been adequately assessed medically for behavioral symptoms and that other preventable reasons have been ruled out. It is important to have detailed documentation with a baseline measure of a resident's behavioral symptoms, therefore if a pattern in behavioral symptoms exists, it can be seen. Without this baseline data on behaviors, it will be difficult to show if any interventions, medications or non-pharmacological interventions have had an impact on the care of residents. Potential causes of behavioral symptoms should be evaluated by the pattern of behaviors exhibited. The evaluator does not always know the causes of anxiety. Any perceived threat to a resident might trigger anxious behaviors. Environmental causes such as lighting, noise level, activity level, room size, etc. should be evaluated as triggers for behavioral symptoms. Examples of physical causes, which can trigger anxiety, are impaired vision/hearing, acute/chronic illness, dehydration, constipation, depression, fatigue, physical discomfort, or medication side effects. It is also important to evaluate emotional causes as a possible trigger for anxiety. Emotional situations, which can trigger anxious behavior, include death of a loved one, selling of the family home or relocation. Just because death is an inevitable process in the life cycle and normally happens later in life does not mean that geriatric residents who experience death of a loved one do not grieve. For residents with dementia, a change in routine, care plan or staff can result in an increase in behavioral symptoms. By determining the cause of those symptoms, treatment can be aimed at reducing the trigger. For example relocation (i.e., switching beds, rooms or even roommates) can be a major stressor for residents and trigger a variety of anxiety related behaviors. Adequately preparing residents prior to a move and involving residents in decision-making processes as much as possible can reduce anxiety related behaviors.

Next, assess the plan of care. Does it address non-pharmacological therapies? These would include such therapies as environmental/stimulus control (i.e., keeping noise levels down around residents who can't handle excessive stimulation) and behavioral therapies (i.e., massage and exercise). Many of these interventions are simple, effective and require about as much time as administering a medication. Psychotherapy is also an option, especially for those residents who have experienced a major emotional loss or physical trauma such as death of a spouse or new onset of a stroke.

It is important to assess the results of the antianxiety therapy. If a resident's anxiety is adequately treated and their quality of life is improved with the use of the medication and consistently applied behavioral interventions, a case can be made to attempt a dose reduction to see if the behavioral interventions will control the behaviors at a lower dose of the medication. If a resident was admitted to your facility on an antianxiety medication, and the resident or representative insists on the use of the medication, then a risk/benefit ratio assessment for use of the medication needs to be made and documented. This assessment will determine if the medication is improving the resident's quality of life with little or no side effects. If the resident is on a routine antianxiety medication and still has behavioral symptoms, then the possibility of the drug causing the behavioral symptoms (i.e., inappropriate dosing or inappropriate drug choice) must be considered. An example would be a resident who is agitated and has difficulty sleeping at night. Benzodiazepines can cause agitation and nightmares. Documentation should be provided in the clinical (Continued on page 4)
record by the prescriber. This should be for residents who are on antianxiety medications functioning at a reasonable level, having no adverse effects, and for whom removing the medication may decrease the quality of life. You need to discuss these issues with the caregivers on all shifts. All staff must be educated about the use and side effects of antianxiety medications. A standard consistent routine is important to limit anxious behaviors in persons with anxiety as well as a review of the implementation of the plan of care for these residents by a multidisciplinary team to evaluate success or the need to modify strategies. The resident’s representative also needs to be informed of the benefits as well as potential adverse effects of the antianxiety medication and what to do if any adverse effects do appear.

Finally, after looking at each individual resident’s care, think about the care of all affected residents. Anxiety is one of the most common psychiatric disorders late in life. Anxiety can cause a variety of physical and psychological behaviors, that left untreated, can decrease the quality of life of residents. Your systematic investigation, including an evaluation of the environment and staffing patterns for conditions that may contribute to the anxious behaviors for which the medication is prescribed should help you identify any patterns or “red flags” that are present in your facility that may be contributing to decreased quality of life for your residents. Your goal should be to minimize inappropriate antianxiety medication use. Following the investigative protocol outlined in the Specific Guide for Antianxiety/Hypnotic Use, provided by CHSRA may be helpful.

How do you respond, if the information shows your facility is generally doing well?

For facilities that are consistently below the 90th percentile, there is still value in the information provided by this QI. First, consider whether the number of residents with antianxiety medications in your facility, or your percentile rankings relative to your peers, is acceptable to you. Are there case-mix concerns that could be contributing to the high percentile ranking? Could you be doing better? Would you like to improve your care to a higher standard? If so, you can follow the investigative protocol outlined in the Specific Guide for Antianxiety/Hypnotic Use, to identify places where you can improve. Look at a sample of those residents flagging on this QI to make sure that you have taken all the necessary steps to provide for their individual needs.

Finally, if you are doing consistently well compared to your peers, you can take the opportunity to determine what it is that you are doing right. Can you identify your best practices for identifying and treating anxious behaviors with non-pharmacological therapies? If so, you can develop a formalized system to use when planning for individual resident plans of care in the future. This system may become a “best practice model” that you can share with other facilities.
New Reports Continued

(Continued from page 1)

quality indicators we submit on your behalf. The plots display the historical progression of long term care monthly quality indicators (QI) values. These values are the same as those found in the quarterly reports we have been sending to you. As with the quarterly reports, we are including values for all of the CHSRA QIs not just those we submit to JCAHO.

Each plot shows the monthly results for the QI identified in the heading. The solid black lines represent your facility’s QI values. The dashed lines represent upper and lower control chart limits equal to the comparison group average plus and minus three standard deviations, respectively. A marker falling outside the control limits is an indication that the facility result is further removed from the comparison group average than most of the other facilities in the group, i.e. the result is an “outlier” relative to the rest of the facilities.

Taken together, the QI plot and report information can help focus your attention on those situations most worthy of investigation. Also, comparison group averages and standard deviations are routinely submitted to JCAHO with the facility-specific QI values. If JCAHO uses a control charting procedure based upon submitted values to guide its agency accreditation surveys, you may be able to prepare for JCAHO’s survey by monitoring the QI plots.

QI Project Updates

• CHSRA Logo and Website: Along with our redesign of the CHSRA website, we created a logo as well. CHSRA has integrated the new logo into our newsletter and website. Over the next six months, you will begin to see it on our other correspondence as well. We hope you like the new look as much as we do!

• PIP/ORYX Members-only Website: As we mentioned in the last newsletter, CHSRA is currently in the process of developing a Members-only Website for facilities who are members of the PIP/ORYX project. We hope to begin beta-testing the site in the fall. If you did not return a survey last quarter and are interested in being part of the test site, please contact Karen McKinney at (608) 265-3445.

• For ORYX Members Only: By July 31, 2001, we will have transmitted 1st quarter (January, February, March 2001) data to JCAHO. You should have already received a copy of that report. Please remember, even though you receive the full QI Profile report from us, we only transmit the performance measures that you have selected. If you have any questions, please feel free to contact Karen McKinney at (608) 265-3445.

• Specific QI Guides: All of the specific QI guides have been completed and published. If your facility is missing any of the specific QI guides, feel free to request them by contacting Karen McKinney at (608) 265-3445.