Antipsychotic Reduction

A Toolkit for Improving Dementia Care in Nursing Homes
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ABOUT THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT TOOLKIT

The Clinical Considerations of Antipsychotic Management Toolkit is a clinically-focused resource containing steps and objectives, expectations at each step, and offers or identifies tools and resources that will help you meet performance expectations and outcomes. It identifies the steps that need to be taken in order to clinically manage individuals who are taking antipsychotic medications, in attempting gradual dose-reduction, and to lower the off-label use of medications.

The model used for the toolkit framework is the Nursing Process, also referred to as the Care Delivery Process, with the addition of two steps. The Nursing Process steps include: recognition/assessment, diagnosis/clinical judgment, outcomes planning, implementation, and evaluation. The additional steps include: leadership and staff training. This model was chosen because it is one that nurses are familiar with, it is comprehensive and ongoing, and incorporates input from various disciplines. The model is a universally acknowledged method used to identify and address complex issues. It is consistent with standard problem-solving and quality improvement.

In keeping with recommended quality improvement approaches, the Leadership and Staff Training sections were added to the toolkit. Nursing center leaders/supervisors need to be invested and lead this quality improvement effort with input from all staff, residents, families and practitioners. This section of the framework details the support leadership must provide to ensure quality improvement success.

The Staff Training section was added to support the need for staff education in order to meet the center’s quality expectations to safely lower antipsychotics.

This toolkit is designed to assist centers in moving toward a more appropriate decision-making process for antipsychotic medication use. However, it does not provide a comprehensive package of all aspects of care.
THE CLINICAL CONSIDERATIONS OF ANTIPSYCHOTIC MANAGEMENT FRAMEWORK
To access the tools or resources, click on the tool/resource name appearing in each section of the framework.

<table>
<thead>
<tr>
<th>STEPS / OBJECTIVES</th>
<th>EXPECTATIONS</th>
<th>TOOLS / RESOURCES</th>
</tr>
</thead>
</table>
| **Leadership**     | • Know your facility’s antipsychotic prevalence rates (short & long-stay) by using CMS Quality Measures (QM) when available, AHCA and/or facility data  
                      • Set a facility antipsychotic quality measurement goal – focus on outcomes  
                      • Make sure all supervisors, staff and physicians are aware of and understand the goal  
                      • Make sure employees know their performance expectations  
                      • Hold employees accountable for following care process steps  
                      • Make regular employee rounds to address questions about the goal  
                      • Ensure all staff are trained on how to identify unmet needs and nurses are trained on recognizing common antipsychotics  
                      • Recognize departments and staff doing well in implementing process and using tools | **Nursing Process Approach for Antipsychotic Drug – Gradual Dose Reduction**  
**Antipsychotic Prescription Log**  
**Sample Facility Policy for Use of Antipsychotic Medications**  
**Sample Antipsychotic Physician Memo**  
LTC Trend Tracker: [www.ltctrendtracker.com](http://www.ltctrendtracker.com) |
| **Recognition/Assessment** | • Be able to recognize antipsychotic drugs commonly used in the LTC setting and the issues surrounding the use of these drugs  
                      • Observe resident behaviors  
                      • Describe behavior/symptom details like onset, intensity, duration, severity to self and/or others  
                      • Identify change in level of consciousness (e.g. alert, drowsy, stuporous, comatose)  
                      • Determine the necessity to control or limit behavior  
                      • Assess mood, thinking, function, and behavior within 24 hours of admission if an individual is taking an antipsychotic or identified as having a behavior problem  
                      • For individuals taking antipsychotics, identify where and why treatment started and how effective/problematic the treatment has been | **INTERACT Care Path for Mental Status Change**: [www.INTERACT2.net](http://www.INTERACT2.net)  
**Other Resources**  
Individual’s medical record, progress notes, hospital discharge summary, MAR, Stop and Watch Reports, and latest MDS assessment |
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<tr>
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<tr>
<td>Diagnosis/Clinical Judgment</td>
<td>Use existing medical information and assessment data to form an opinion about probable cause(s) of behavior/symptom</td>
<td>Approaches to Considering Causes of Behavior Algorithm</td>
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<tr>
<td></td>
<td>Evaluate the current medical regimen as the potential source of behavior/symptom</td>
<td>Guidance to Using the Behavioral Approach Algorithm</td>
</tr>
<tr>
<td></td>
<td>• Review assessment and observation data</td>
<td>INTERACT Change in Condition Cards: <a href="http://www.INTERACT2.net">www.INTERACT2.net</a></td>
</tr>
<tr>
<td></td>
<td>• Evaluate psychiatric reports</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contact family and/or others who may provide insight about behavior or add to medical history</td>
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<tr>
<td></td>
<td>• Systematically determine if the behavior/symptom(s) are likely related to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° medical condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° use of an antipsychotic drug</td>
<td></td>
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<tr>
<td></td>
<td>° the current medication regimen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° psychosocial/unmet need</td>
<td></td>
</tr>
<tr>
<td></td>
<td>° environmental cause</td>
<td></td>
</tr>
<tr>
<td>Outcomes Planning</td>
<td>Collect pertinent information as the basis for having identified a specific cause or causes of the problematic behavior/symptom</td>
<td>Antipsychotic Medication Tapering Checklist</td>
</tr>
<tr>
<td></td>
<td>• Contact your consultant pharmacist to identify/verify high risk medications most likely related to behavior/symptom</td>
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<td></td>
<td>• If antipsychotic drug use is likely part of the problem, consider discussing possible gradual dose reduction or drug discontinuance with the physician</td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td>Organize and prepare assessment findings and information to be discussed with the physician</td>
<td>Antipsychotic SBAR</td>
</tr>
<tr>
<td></td>
<td>Identify specific goals for managing the behavior/symptom</td>
<td>What Is CHAT?</td>
</tr>
<tr>
<td></td>
<td>After consultation with the physician, document the basis for having identified the problem/symptom(s) and basis for the cause of behavior/symptom</td>
<td>Relevant CHATs</td>
</tr>
<tr>
<td></td>
<td>• Collaborate with practitioners to identify possible urgent situations such as delirium or psychosis</td>
<td>Agitation CHAT</td>
</tr>
<tr>
<td></td>
<td>• Discuss your finding with the practitioner and work together to form a care plan and next steps</td>
<td>Altered Mental Status CHAT</td>
</tr>
<tr>
<td></td>
<td>• Discuss and document why causes were not sought or efforts to identify them were not fruitful</td>
<td>Dizziness/Unsteadiness CHAT</td>
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<tr>
<td></td>
<td>• Implement/update care plan to address causes of behavior/system(s)</td>
<td>Fall CHAT</td>
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<td>• If indicated, develop a plan to taper or discontinue antipsychotic treatment</td>
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<td></td>
<td>• As much as possible, the plan should include non-pharmacological and behavior management strategies</td>
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<td></td>
<td>• Adapt or adjust the environment to minimize related causes</td>
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<td></td>
<td>• Include family in the plan development and approval of plan</td>
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<tr>
<td></td>
<td>• Document in the medical record the basis for interventions</td>
<td></td>
</tr>
<tr>
<td>STEPS / OBJECTIVES</td>
<td>EXPECTATIONS</td>
<td>TOOLS / RESOURCES</td>
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<td>--------------------</td>
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</tbody>
</table>
| **Evaluation**     | • Monitor for care plan effectiveness  
                      • Review each resident’s medication regimen for high risk medications and the appropriateness of continued use of any antipsychotic or other psychopharmacological medications  
                      • Form a Behavior Management Team to identify unmet needs and monitor and document the effectiveness of interventions | **Antipsychotic Medication QA Review Tool**  
**Assessment of Resident Receiving Psychotropic Medication** |
|                    | **Staff Education**  | **Antipsychotic Drugs Common Terms and Definitions**  
**Case Study 1: Behavior Issues in a Resident Who is Already Receiving Psychopharmacological Medications**  
**AHCA’s Suggested Tools for Reducing Off Label Use of Antipsychotics: How These Tools Can Improve Regulatory Compliance**  
**University of Iowa – Improving Antipsychotic Appropriateness in Dementia Patients** | https://www.healthcare.uiowa.edu/igec/IAADAP T |
LEADERSHIP

USING THE NURSING PROCESS APPROACH TO CONSIDER GRADUAL DOSE REDUCTION (GDR)
Tapering For Off-Label Use of Antipsychotic Medications

The best approach to considering GDR is person-centered. Before contacting the individual’s physician to discuss potential dose reduction, it is important for the nurse to follow the nursing process and gather observations and pertinent information. The nursing process uses clinical judgment to strike a balance between personal interpretation and research evidence. The process fosters the use of critical thinking to categorize clients issue and course of action. Below, the nursing process is applied to the nurse’s role when considering the potential for GDR for off-label use of antipsychotic medication.

Nurse/Interdisciplinary Team Assessment

- Conduct an assessment and identify conditions possibly related to drug side-effect(s).
- Review most recent MDS assessment for mood, function, behavior, evidence of delirium and facility-based behavior tracking record. Compare to findings of the just completed assessment. Review most recent scoring tool (e.g., AIMS) and compare to prior score.
- Review medical record taking note of:
  - Psychiatric conditions, psychiatric hospitalizations, abnormal clinical and lab findings, and related physician, pharmacist, and psychologist notes.
  - Any GDR attempts during past 6 – 12 months and the outcome
- For individuals staying in the facility for longer periods of time:
  - Check the pharmacist’s recommendations recorded on the monthly medication regimen review for information related to drug doses, duration and continued need.
- Review the CNA Stop and Watch reports for changes in behavior, cognition, mood, ADL performance, and daily routine. (Stop and Watch is an INTERACT II tool).

Diagnosis/Clinical Judgment

- Identify symptoms that may be related to antipsychotic medication side-effects.
  - e.g. orthostatic hypotension, increase weight gain, increase glucose level, urinary retention, constipation, sedation, akathisia (restlessness, pacing, inability to sit still, anxiety, sleep disturbance), dystonia/torticollis - stiffness of neck, pseudoparkinsonism (drooling, tremors, rigidity, bradykinesia - slowness of movement, cogwheel rigidity - jerk responses of body muscles when force is applied while bending a limb), tardive dyskinesia (lip smacking/chewing, abnormal tongue movement, involuntary movement of arms/legs), dry mouth, blurred vision, worsening confusion/delirium, edema, blood abnormalities (increased triglycerides)
  - Evaluate if symptoms are old or new
- Is the individual at optimal ADL function and quality of life?
- Will GDR/tapering possibly improve the individual’s symptoms and functioning?
Outcomes/Planning

• Gather clinical information and diagnoses.
  o Include all medications currently taken by the individual, including:
    ▪ Dosages and times of administration
    ▪ Which of these medications may be contributing to issues and concerns?
• Gather information about drug considered for GDR
  o Current dose, time(s) of drug administration, and method of administration (tablets, capsules, liquid, injectable, IV).
  o How long has the individual been taking this drug?
  o Is the current drug dose at the lowest available dose? If so, does the dose provide the individual optimal quality of life and ADL functioning?
• Identify the non-pharmacological approaches used to help address challenging behavioral responses. Did these approaches work?
• Note assessment findings in the medical record.

Implementation

• Complete the SBAR designed for nurse consideration of antipsychotic medication GDR.
• If the individual is over-sedated:
  o Hold the drug until the physician is contacted.
  o A lower dose or a different medication may be used if behaviors or symptoms requiring antipsychotic treatment emerge.
• Attempt non-pharmaceutical approaches to help address challenging behavioral responses (examples include: music therapy, exercise).
• When possible, inform the individual and his/her family and care staff about the plan for GDR to gain their understanding and support.
• Call the physician to discuss possible medication discontinuance or tapering.

Evaluation

• Assess the individual’s response to medication discontinuance or tapering.
• After one month, determine if the individual is at optimal ADL functioning and has an improved quality of life.
  o Repeat any clinical tests and labs ordered by the physician, and evaluate for improvement.
  o Evaluate the effectiveness of non-pharmaceutical approaches to challenging behavioral responses that have been employed, document and change if needed.
• Continue to evaluate and note medication reduction responses in the medical record. Notify the physician about further tapering or drug maintenance as necessary.
RECOMMENDED PHYSICIAN GUIDELINES FOR GDR

• Periodically review the progress of any resident receiving antipsychotic medications, including the frequency, duration, and intensity of any symptoms
• Review the resident’s overall condition and symptoms, to identify anything else that may be impairing behavior or mood stability
• At any time, if it is uncertain whether a psychopharmacological medication (including antipsychotic medications) is making a difference, consider initiating a trial reduction (e.g., lower dose, lesser frequency of administration) to see the effects
• If behavior is worse or at least not stable within 72 hours of initiating a psychopharmacological medication (including antipsychotic medications), review the working diagnosis and treatment to see whether a change in treatment may be indicated.
• For an antipsychotic medication prescribed for an acute episode (for example: during a recent hospital stay), consider a trial dose reduction if the medication’s effectiveness or the need for continued treatment is uncertain.
• If the drug is currently at the lowest dose, consider a different approach to dose reduction (e.g., fewer doses per day, treatment every other day).
• It is generally prudent to reduce doses gradually (over several days to several weeks), to be able to observe for effects of medication reduction and to allow the brain to adjust to changes in chemical balances.
• For individuals taking an antipsychotic drug for one year, attempt dose reduction in two separate quarters with at least one month apart unless the individual is at optimal functioning.
• After longer than one year of drug therapy, attempt drug reduction once per year. If GDR is unsuccessful after two or more attempts, further reduction may be “clinically contraindicated.” Documentation is needed in the individual’s record why additional dose reduction will cause impairment, psychiatric instability, or exacerbate the underlying psychiatric disorder.

RESOURCES


The Long Term Care Survey, F-TAG 329. AHCA October 2010 Edition, pp. 441-555


Ryan Carnahan, Phar.D., M.S., BCPP, Assistant Professor (Clinical), The University of Iowa College of Public Health, Recommendations offer to Dr. Gifford, February 27, 2012
ANTIPSYCHOTIC PRESCRIPTION LOG

Download this Excel tool to help keep track for antipsychotic medication use in your organization.
SAMPLE FACILITY POLICY FOR USE OF ANTIPSYCHOTIC MEDICATIONS

(Facility Name)__________________________ recognizes that antipsychotics benefit only some residents and can be associated with side effects and risks. Therefore, when antipsychotic medications are used in our facility, the facility will identify target behaviors and implement a care plan with both non-pharmacological and pharmacological interventions. Potential adverse drug reactions and side effects will also be evaluated along with a plan for periodic attempts at dose reduction, where indicated or unless clinically contraindicated.
SAMPLE FACILITY MEMO TO PHYSICIANS ON ANTIPSYCHOTIC MEDICATION USE

Date:

To: Facility Physicians  
From: Facility Administrator / DON

Dear Doctors:

On May 30, 2012 Centers for Medicare and Medicaid (CMS) announced the Partnership to Improve Dementia Care, an initiative to ensure appropriate care and use of antipsychotic medications for nursing home patients. This partnership consists of federal and state entities, nursing homes and other providers, advocacy groups, and caregivers. The initiative was spurred by research showing that one quarter of Medicare beneficiaries in nursing homes are prescribed antipsychotic medications and that the use of these drugs may be beneficial but may also be associated with increased risk of death.

According to federal guidance, antipsychotics should not be used if the only indication for drug use is one or more of the following issues: wandering, poor self care, restlessness, impaired memory, anxiety, depression (without psychotic features), insomnia, unsociability, indifference to surroundings, fidgeting, nervousness, uncooperativeness, or agitated behaviors that do not represent a danger to the resident or others. CMS requires attempted gradual dose reductions of the antipsychotic and the use of behavioral interventions (unless clinically contraindicated).

In keeping with the Partnership to Improve Dementia Care, _____________________________ Nursing Center is focusing on dementia care and reducing the use of antipsychotic medications, when possible, to address disruptive behaviors. We would like you to be aware of our effort and to support our clinical staff in managing behavioral issues with the limited use of antipsychotics and to consider gradual dose reductions or eliminate medication use for individuals without a history of psychiatric illness or current psychiatric symptoms.

We appreciate your support in helping us provide the best possible care to the individuals we serve. If you have any questions or need further information, please contact _____________________________ (DON) at _____________________________ (phone number).

We cannot achieve success without you!
Approach to Considering Causes of Behavior

Rule out underlying potentially treatable conditions

Does the individual have delirium or other medical causes?

Identify and manage specific medical causes (e.g., medications, fluid/electrolyte imbalances, infections)

Does the individual have delusions and/or hallucinations?

IF severe psychotic symptoms, consider aggressive medication treatment. IF less severe symptoms: consider nonpharmacological interventions primarily

Does the individual have symptoms of a mood disorder?

IF mild to moderate: start with nonpharmacological measures. IF severe, consider medication

Does behavior of concern persist?

Is behavior causing substantial distress or risk of harm to self/others?

Review and reconsider diagnosis and any current interventions. Identify and address underlying needs

Consider new or modified medication regimen, as indicated, based on appropriate protocols

Identify and address underlying needs on ongoing basis
GUIDANCE TO USING THE CONSIDERING CAUSES OF BEHAVIOR ALGORITHM

How to Use the Algorithm

This algorithm, entitled, “Approach to Consider Causes of Behavior,” is intended to provide a framework for thinking about medical and psychiatric conditions that cause or contribute to behavior, especially when:

• The situation is not simple (that is, something other than a straightforward intervention that readily corrects an identifiable cause).
• The causes are unclear.
• Interventions have been based mostly on conjecture.
• Behavior details or patterns are markedly different than baseline or anticipated.
• Behavior is accompanied by other symptoms, abnormalities or changes in condition, such as falling, loss of appetite, unstable vital signs, breathing difficulty, and change in level of consciousness.
• The individual is getting worse despite interventions, or initial or previous interventions are not working or not working as well as anticipated.

How to Do Cause identification

The algorithm focuses on cause identification. Cause identification is always preceded by recognition, description (organizing a story of what is happening) and assessment (gathering details). Effective cause identification (including, for doctors, diagnosis) depends heavily on the clarity and pertinence of information gathered by the nurse during assessment and the organization and completeness of the “story” of the situation.

The cause identification steps include:

• Observe and describe the situation in detail (what happened, in what sequence, who was involved, when, how often, how severe, etc.) and give the sequence of events before, during, and after the behavior occurred.
• Gather more details about the individual (past history, medications, environment, specific findings such as presence of hallucinations or paranoia, etc.).
• Organize the information.
• Plan by identifying appropriate interventions, based as much as possible on the thinking about likely causes.
• Review the information with a practitioner and discuss what the information leads to about possible or likely underlying causes.

When to Use the Algorithm

The algorithm is designed for nurses and practitioners. It can be used at a safety meeting/huddle or any interdisciplinary team meeting about the resident where the underlying causes of behavior are discussed.

For more direction on how to identify the causes of behavior, go to the Case Study 1: Antipsychotic Drug issues.
## OUTCOMES PLANNING

### ANTIPSYCHOTIC MEDICATION TAPERING CHECKLIST

<table>
<thead>
<tr>
<th>Tapering More Likely to Succeed If</th>
<th>Potential Problems If</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a clear and detailed picture of the individual’s cognition, mood, and behavior, including accurate diagnoses and identification of underlying causes</td>
<td>The picture of the individual's cognition, mood, and behavior are muddled, with vague descriptions, questionable or unconfirmed diagnoses, and unclear identification of underlying causes</td>
</tr>
<tr>
<td>The individual does not have delirium or acute psychosis</td>
<td>The individual has delirium or acute psychosis</td>
</tr>
<tr>
<td>The individual was not recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function</td>
<td>The individual was recently ill or hospitalized with significant medical illness that has affected mood, behavior, cognition, or function</td>
</tr>
<tr>
<td>Individual’s behavior and mood have been stable for an extended period (weeks to months)</td>
<td>Individual’s behavior and mood have been unstable in recent weeks or only stable for several weeks</td>
</tr>
<tr>
<td>The reason why an antipsychotic was started is clear, based on reliable information</td>
<td>The reason why an antipsychotic was started is unclear and/or speculative</td>
</tr>
<tr>
<td>The individual is not taking any other medications that can cause psychosis and/or adversely affect behavior or mood</td>
<td>The individual is taking other medications (in any category, not just psychopharmacological medications) that can cause psychosis and/or adversely affect behavior or mood</td>
</tr>
<tr>
<td>There are specific goals related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms</td>
<td>There are no specific goals, or only vague ones, related to target symptoms and a pertinent approach to documenting, monitoring, and reporting those target symptoms</td>
</tr>
<tr>
<td>A practitioner is available and willing to help staff reassess the individual’s status during the period of medication tapering</td>
<td>A practitioner is unavailable, unable, or unwilling to help staff reassess the individual's status during the period of medication tapering</td>
</tr>
<tr>
<td>The individual (where feasible) and family (or other substitute decision maker) are involved in the plan for tapering medication and monitoring results</td>
<td>The individual (where feasible) and family (or other substitute decision maker) are not involved in the plan for tapering medication and monitoring results</td>
</tr>
<tr>
<td>Effective non-pharmacological interventions have been instituted</td>
<td>Non-pharmacological interventions have not been successful in preventing or controlling symptoms</td>
</tr>
<tr>
<td>Previous attempts at tapering psychopharmacological medications were successful, and symptoms have not recurred to any significant extent</td>
<td>Previous attempts at tapering psychopharmacological medications were unsuccessful, and/or medications have had to be restarted previously or added, due to recurrence of significant symptoms</td>
</tr>
</tbody>
</table>

Using of the checklist:
1. Check off the applicable boxes for each of the 10 rows above.
2. Count the number of boxes checked in each column.
3. Tapering of an antipsychotic medication is more likely to succeed if substantially more items in the left-hand column are checked compared to the right-hand column.
4. To the extent possible, address the issues checked off in the right-hand column before or while attempting to taper an antipsychotic medication, in order to make successful tapering more likely.
IMPLEMENTATION

SBAR

Physician/NP/PA Communication and Progress Note

To Discuss Possible Drug Reduction for an Individual

Already Receiving an Antipsychotic Drug for Off-Label Use

Before Calling the MD/NP/PA:

__ Evaluate the patient and complete the SBAR form
__ Check VS: BP, pulse, respiratory rate, neurological check, lung sound, temperature, pain level
__ Review chart for:
  • psychiatric conditions and/or hospitalizations
  • recent physician or psychologist progress notes
  • pharmacist medication regimen review notes
__ Be prepared to report on dosing changes, changes in target symptoms and potential side effects
__ Have relevant information available when reporting (medication list including doses, method and time(s) of administration)
__ Be prepared to have a list of all medications, including PRNs, and the individual's medical record

Situation

The drug and behavior (if problematic) I am calling about is ____________________________________________
Date drug started ___/___/___
Date of last dose adjustment and dosage change made ___/___/___
Individual's symptoms has gotten worse/better/stayed the same since the drug started ________________
Have any potential side effects been noticed? __No __Yes (If yes describe)
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Things that make the symptoms worse
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Things that make the symptoms better (non-pharmacological approach)
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Other things that have occurred related to this symptom and treatment
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Background

Primary diagnosis and/or reason person is at the nursing home
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Pertinent mental health history
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Behavioral concerns identified by family
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Vital signs       BP______/______  HR______  RR______  Temp______
Individual is on a scheduled pain management program ____Yes ____No
If yes, what medication interventions is the individual receiving?
Conditions (check all those that apply)

☐ orthostatic hypotension  ☐ lip smacking/
drooling  chewing/abnormal tongue  
weight gain  tremors  movement  
increase glucose level  rigidity  
urinary retention  slowness of movement  
constipation  jerk body responses  
sedation  involuntarily movement of  
restlessness  extremities  
pacing  worsening  
drooling  confusion/delirium  
tremors  fall  

Other ______________________________________

Medication changes or new orders in the last two weeks ________________________________________________

Recent Labs __________________________________________________________________________________

Allergies _____________________________________________________________________________________

Any other data ________________________________________________________________________________

Assessment (RN) or Appearance (LPN)

(For RNs): The individual’s symptoms appear (better/worse/same) ____________________________________________

I think the symptoms may be related to ________________________________________________________________

Do you believe the individual has achieved a therapeutic dose? ___ No  ___Yes  If yes: Do you believe dose reduction
may be needed? ____________________________________________________________ 

(For LPNs): The individual’s symptom(s) appear (better/worse/same) ________________________________________

Request

I suggest or request (check all that applies):

☐ Other (start/change non-pharmacological approach)
☐ Change in/stop current med order(s)
☐ Provider visit (MD/NP/PA)
☐ Continued monitoring
☐ Lab work

Staff name ________________________________________ RN/LPN

Reported to: Name _______________________________ (MD/NP/PA)

Date___/___/___  Time___AM/PM

If to MD/NP/PA, communicated via: ____________________________

Phone (___) _____ - ______  In-person __

Progress Note (complete and place SBAR/progress note in medical record)

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

__ Family or health care proxy notified

Return call/new orders from MD/NP/PA  Date___/___/___  Time___/___AM/PM

_____________________________________________________________________________________________

Signature________________________________________ RN/LPN  Date___/___/___  Time___/___AM
**WHAT IS CHAT?**

CHAT stands for Communicating Health Assessments by Telephone. It is a quality improvement program to enhance telephone communication between the nurse and the physician.

The quality improvement program was developed by Heather Whitson, MD, S. Nicole Hastings, MD, Deborah Lakan, RNC, MSN, Richard Sloane, MPH, Heidi White, MS and Eleanor McConnell, RN, PhD from the Department of Medicine and the Center for the Study of Aging and Human Development and School of Nursing at Duke University, Durham, NC. The program was studied and conducted at Extended Care and Rehabilitation Center, Durham Veterans Affairs Medical Center. Funding support was provided by the AMDA Foundation and the John A. Hartford Foundation.

The purpose of the study program was to improve the communication of health assessment by telephone and determine whether satisfaction of on-site nurses improved after the CHAT intervention.

CHATs are point-of-care decision support tools adapted from the 2004 American Medical Director’s Association (AMDA) protocols. They represent 16 common clinical problems found in long term care settings. The common conditions include:

<table>
<thead>
<tr>
<th>Abdominal Pain</th>
<th>Agitation</th>
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<tbody>
<tr>
<td>Confusion</td>
<td>Altered Mental Status</td>
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<tr>
<td>Bloor pressure</td>
<td>Low Blood Pressure</td>
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<tr>
<td>Chest pain</td>
<td>Constipation</td>
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<tr>
<td>Diarrhea</td>
<td>Dizziness/Unsteadiness</td>
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<tr>
<td>Dyspnea/Shortness of Breath</td>
<td>Fall</td>
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<tr>
<td>Fever</td>
<td>Hyperglycemia</td>
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<tr>
<td>Hypoglycemia</td>
<td>Musculoskeletal Complaint</td>
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<tr>
<td>Nausea or Vomiting</td>
<td>Urinary Complaints or Positive urinalysis</td>
</tr>
</tbody>
</table>

Each CHAT is designed to identify pertinent information that needs to be assessed and communicated for the specific clinical issue. The tools focus on the questions needing to be answered and the examinations needing to be conducted before calling the physician.
Patient Name: ____________________
Date of Birth: ____________________
Medicaid Record Number: _________

CHAT: AGITATION/CONFUSION/ALTERED MENTAL STATUS

History
How long ago did the symptoms start? Tell the story: ________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Other symptoms or events in the last 24 hours:

Fall
Constipation
Medication changes
Cough
Fever
Pain
Urinary symptoms

Exam
Current vital sign ________________________________________________________________
Oxygen saturation ______________________________________________________________
Finger stick (blood glucose), if diabetic _____________________________________________

Other pertinent information may include neurological assessment, signs of injury, dehydration or infection.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Staff Name: ____________________________________________ RN/LPN

Reported to:
Name: ___________________________ (MD/NP/PA) Date: __________ Time: _____ am __ pm __
If to MD/NP/PA, communicated via: ____________ Phone ____________ In person

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: __________________

CHAT Progress Note

**Progress Note** (complete and place CHAT/progress note in medical record)

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Return call/new orders from MD/NP/PA                                           Date___/___/___
Time___/___AM/PM

Signature________________________________RN/LPN             Date___/___/___
Time___/___AM/PM

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: _________________

CHAT: DIZZINESS/UNSTEADINESS

History
How long ago did this symptom start? Tell the story: ____________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Has the patient had these symptoms on other occasions? Tell the story: ______________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Any changes to the medication list or doses in the last week? ___________________________
If yes, what medication changed? _____________________________________________

Any PRN medication doses given in the last 24 hours?
If yes, what medication? ____________________________

Exam
Blood pressure and pulse (sitting and standing): ___________ and ________________
Finger stick (blood sugar), if diabetic: ___________________________________________________________________

Other pertinent information may include a neurologic exam and assessment of mental status.
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Staff Name: _______________________________________________________________

Reported to:
Name: ______________________________ (MD/NP/PA)   Date: _______ Time: _____ am ___pm ___

If to MD/NP/PA, communicated via: ___________ Phone ___________ In person ______

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: _________________

CHAT Progress Note

**Progress Note** (complete and place CHAT/progress note in medical record)

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Return call/new orders from MD/NP/PA  Date___/___/___
Time___/___AM/PM

Signature________________________________RN/LPN  Date___/___/___
Time___/___AM/PM

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: _________________

CHAT: FALL

History
Is the patient having new pain anywhere since the fall? Tell the story: _________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Did the patient hit his/her head? Tell the story: _________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Any loss of consciousness before or after the fall? Tell the story: _________________
_____________________________________________________________________________
_____________________________________________________________________________

Exam
Can the patient ambulate as well as he/she could before the fall? _________________

Any obvious injuries (lacerations, deformities)? _________________

Blood pressure and pulse (sitting and standing) _________________

Other pertinent information may include joint assessment for range of motion, assessment of mental status (level of consciousness, orientation, speech), blood glucose if patient is diabetic.
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Staff Name: ___________________________ (RN/LPN) _____________

Reported to:
Name: ___________________________ (MD/NP/PA) Date: ________ Time: _______ am __ pm __

If to MD/NP/PA, communicated via: ________ Phone _____________ In person

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University.)
Patient Name: ___________________________
Date of Birth: ___________________________
Medicaid Record Number: ____________________

CHAT Progress Note

Progress Note (complete and place CHAT/progress note in medical record)

_____________________________________________________________________________________
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__ Family or health care proxy notified
Return call/new orders from MD/NP/PA Date___/___/___
Time___/___AM/PM

Signature________________________________RN/LPN Date___/___/___
Time___/___AM/PM

(This CHAT has been modified by AHCA. The original CHAT is a product of Duke University)

Developed by
Heather Whitson, MD; Susan N. Hastings, MD; Eleanor McConnell, RN, PhD (GRECC)

ECRC Steering Committee:
Cheryl Barker, RN; Alison Bingman, GNP; Nicole Davis, GNP; Linda Fish, RN; Lily Foster, RN; Mary Francis, RN; Ruth Frank, RN; Lorraine Galkowski, RN; Linda Heeg-Krause, RN, Carol Paniccia, RN;
Jennifer Shaffer, RN; Mary Tatum, RN; and Janette Warsaw, RN

Designed by
Lesa Hall, Medical Illustrator

Reference:
AMDA – Protocols for Physician Notification 2004

Funding Support:
AMDA Foundation and the John A. Hartford Foundation
EVALUATION

ANTIPSYCHOTIC MEDICATIONS QA REVIEW TOOL

The Antipsychotic Medications QA Review Tool is intended to be used by centers to help evaluate prescribing and gradual dose reduction decision making practices. The tool is structured to follow nursing process and should be used to evaluate adherence to process with regard to treatment and care plan decisions involving medication use, reduction or discontinuation. Evaluate question responses to determine practice improvement areas.

<table>
<thead>
<tr>
<th>RECOGNITION</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is there documentation of the details of any potentially problematic behavioral responses?</td>
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<tr>
<td>2. Is there a clearly documented rationale for why a behavioral response is considered problematic?</td>
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<tr>
<td>3. Is there documentation of a careful review of the medication regimen, including review for medications that impact behavior, mood, and cognition?</td>
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</table>

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<thead>
<tr>
<th>CAUSE IDENTIFICATION</th>
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<tr>
<td>4. Is there documented effort to review underlying medical and nonmedical causes of problematic behavioral responses, beyond attributing them to dementia or sundowning?</td>
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<tr>
<td>5. Did you ask the resident and/or the family directly about a possible cause/trigger of their behavior?</td>
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<td>6. Are direct caregivers consulted about possible cause/trigger of behavior?</td>
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</table>

<table>
<thead>
<tr>
<th>MANAGEMENT</th>
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<tr>
<td>7. Are there specific goals and objectives for responding to a resident’s behavioral expressions?</td>
<td></td>
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<tr>
<td>8. Is there a documented rationale for choosing and implementing specific interventions, including non-pharmacological approaches?</td>
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<tr>
<td>9. Is there a documented rationale for initiating or continuing to use any medications in any category that can affect mood, cognition, level of consciousness, or behavior?</td>
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<tr>
<td>10. Is the resident and family involved in the decision to stop or continue medication and other care plan decisions?</td>
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<tr>
<th>MONITORING</th>
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<tr>
<td>11. Is there evidence of ongoing monitoring/documentation of an individual’s responses to interventions and related adjustment of interventions?</td>
<td></td>
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<tr>
<td>12. Is there evidence of ongoing monitoring/documentation for complications of any interventions and for addressing the causes of such complications?</td>
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<tr>
<td>13. Is there a documented rationale, included in the care plan, for initiating, continuing, or modifying any interventions, including antipsychotics?</td>
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</table>
ASSESSMENT OF RESIDENT RECEIVING PSYCHOTROPIC MEDICATION

The goal of this assessment is to review residents who are receiving psychopharmacological medications. The tool can be used to guide discussion in reviewing resident behavior during Risk or Care Management and/or Standards of Care Committee meeting where appropriate interdisciplinary members are in attendance, for example, Pharmacy Consultant, Medical Director, Behavioral Health Specialists, etc.

Use this tool for all residents admitted on psychotropic drugs and periodically after the medication has been started and/or severity of symptoms noted.

Resident Name: ________________________________________________________________
Date of Admission: _____________  Date of initial medication assessment: _______________

Previous living arrangements prior to admission (check appropriate selection):
   Home ___  AL ___  SNF ___  Other _______________ ______________
BIMs Score * _______  Date ________     or    MMSE Score*__________Date __________

List psychotropic drugs including antipsychotics, anxiolytics, sedative/hypnotics, antidepressants, and other drugs used to treat psychiatric/behavioral disorders or symptoms

<table>
<thead>
<tr>
<th>Drug Name/Dose</th>
<th>Directions</th>
<th>Diagnosis/Indication</th>
<th>Start Date (If known)</th>
<th>Effective/Side Effects</th>
</tr>
</thead>
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</table>

Behaviors that prompted initiation of above medications; if not known, describe behaviors observed since admission: ________________________________________________________________

Discussion at meeting is focused on effectiveness and relevance of continuing the medication. Also consider potential benefits of tapering and/or a trial off of psychotropic drugs, especially of antipsychotics and hypnotics. The following questions may prompt discussion.

- Have non-drug interventions been attempted in the past? If so, what have been the results and what interventions have been used?
- Has pain been assessed and managed?
- What are the possible needs the resident may be trying to communicate behaviorally?
- Are behaviors causing negative outcomes/ disturbing for the resident?
- Could behaviors be addressed by staff intervention instead of medication?
Could behaviors be addressed by staff intervention instead of medication?

Can these interventions be implemented routinely? If not, what are the barriers?

Have medical causes been addressed? (i.e. metabolic and endocrine disorders, infections. etc.)

Is staff response contributing to or increasing behaviors?

Are families concerned about behaviors typically found in AD?

Are family interactions with resident contributing to or increasing behaviors?

Previous successes or failures with medications?

Is the resident experiencing side effects from the medications? Are there other medications that might be contributing to behaviors?

Would a tapering or trial off antipsychotic or hypnotic meds be appropriate at this time?

If so, why? If not, why not? __________________________________________________________

Note: If a tapering or trial off is implemented, monitor carefully using behavior monitoring sheets.

Summary of discussion: ______________________________________________________________

Recommendation(s) and Action Plan: __________________________________________________

Identify team members completing this assessment: __________________, ______________, ______________, ______________, ______________, ______________.

Date of follow up assessment: ______________________________________________________

Summary of behaviors since changes implemented: ______________________________________

Further recommendation(s) and Action Plan: _________________________________________

Identify team members completing this assessment: __________________, ______________, ______________, ______________, ______________, ______________.

* MMSE – Mini Mental State Exam     BIMs – Brief Interview of Mental Status
ANTIPSYCHOTIC DRUGS – COMMON TERMS & DEFINITIONS

Atypical Antipsychotic (Second Generation) – Is a newer class of antipsychotic medication approved by the U.S. Food and Drug Administration (FDA) primarily for the treatment of schizophrenia and bipolar disorder.

There are currently 9 FDA-approved atypical antipsychotic drugs including:
1. Aripiprazole (Abilify) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder
2. Asenapine (Saphris) – Schizophrenia and bipolar disorder
3. Clozapine (Clozaril) – Schizophrenia (restricted distribution)
4. Iloperidone (Fanapt) – Schizophrenia
5. Olanzapine (Zyprexa) – Schizophrenia, Bipolar, and as added therapy for treatment-resistant major depressive disorder
6. Paliperidone (Invega) – Schizophrenia and schizoaffective disorder
7. Quetiapine (Seroquel) – Schizophrenia, Bipolar, and as added therapy for major depressive disorder (Seroquel-XR)
8. Risperidone (Risperdal) – Schizophrenia and Bipolar
9. Ziprasidone (Geodon) – Schizophrenia and Bipolar

Behavioral Interventions are individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident’s distressed behavior.

Black Box Warning refers to the FDA warning to communicate the risks associated with increased mortality in elderly patients with dementia-related psychosis treated with antipsychotic drugs.

Environmental Causes of Behavior are situations or factors external to the individual that may cause or contribute to exacerbations of behavior and psychiatric symptoms; for example, level/type of stimulation, noise, confusion, lighting, caregiver approach, institutional routines/expectations, and lack of cues.
Extrapyramidal symptoms (EPS) are neurological side effects of medications (including, but not limited to, antipsychotic medications) that result from an imbalance of the extrapyramidal nervous system. EPS includes various syndromes such as:

- Akathisia, which refers to a distressing feeling of internal restlessness that may appear as constant motion, the inability to sit still, fidgeting, pacing or rocking.

- Pseudoparkinsonism is a syndrome of Parkinson-like symptoms including tremors, shuffling gait, slowness of movement, expressionless face, drooling, postural unsteadiness and rigidity of muscles in the limbs, neck and trunk.

- Dystonia, which refers to an acute, painful, spastic contraction of muscle groups (commonly the neck, eyes and trunk) that often occurs soon after initiating treatment and is more common in younger individuals.

Gradual Dose Reduction (GDR) is the stepwise tapering of a dose of medication to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued.

Off-Label use of Antipsychotic Antipsychotic drug used for indications other than those that are approved by the FDA.

Psychiatric Causes of Behavior are commonly recognized disorders (e.g., depression, delirium, psychosis, personality disorders) that appear to cause or contribute to behavior and related symptoms.

Psychoactive Medication (or Psychotropic Medication) is a chemical substance that crosses the blood-brain barrier and acts primarily upon the central nervous system where it affects brain function, resulting in changes in perception, mood, consciousness, cognition and behavior.

Typical Antipsychotic (First Generation Antipsychotics, Neuroleptics, or Major Tranquillizers) refers to the original group of medications that were first used successfully to treat primary psychotic disorders such as schizophrenia. Common First Generation drugs include Compazine, Haldol, Loxitane, Mellaril, Moban, Navane, Orap, Prolixin, Stelazine, Thorazine, and Trilafon.

Unmet Physical Needs are basic human physical conditions or needs that have yet to be satisfied, for example; pain, illness, hunger, sleep disturbance, constipation, elimination needs. {NOTE: Medication is not a physical need; it is a treatment for physical or other needs.}

Unmet Psychological Needs are imbalances related to basic human emotions, for example; loneliness, boredom, apprehension, worry, fear, lack of socialization, loss of intimacy.
CASE STUDY 1: BEHAVIOR ISSUES IN A RESIDENT WHO IS ALREADY RECEIVING PSYCHOPHARMACOLOGICAL MEDICATIONS

The Story - Part 1

The Patient: Mr. Donald Lee, born in February 1925, admitted to the facility in September 2011.

Problem Statement: Donald is an 87-year-old male with advanced dementia who has been a resident in the facility for 5 months. Until recent weeks, he had been relatively stable. In the past few weeks, His behavior issues have become more frequent, problematic and unpredictable. He had become increasingly restless and combative over several weeks. Sleep was very poor with continuing restlessness throughout the night. He has had a colostomy for several years. Recently, he had begun pulling on and dislodging his colostomy. He has become increasingly combative and restless, with a shorter than usual attention span. Repeated efforts to redirect his behavior failed. He talks incessantly and despite being asked repeatedly about personal needs, his responses were not relevant. He has a very short attention span. Staff was unable to keep him engaged in any activities.

“The Story” – Background:
• Donald was admitted to the facility immediately after hospitalization due to a fall down steps at home that caused a subdural hematoma.
• Admission diagnoses included cerebellar mass, subdural hematoma, dementia, dysphagia, atrial fibrillation, peripheral vascular disease, hypertension, COPD, hypothyroidism, polymyalgia rheumatica, glaucoma, history of resected rectal carcinoma with colostomy and depression.
• Donald had lived at home with his wife, who comes and visits him daily. He has a daughter who is very involved in his care.
• During his working days, Donald was a Marine. He has been retired for many years. He was a smoker and has significant chronic obstructive pulmonary disease (COPD) and heart disease.

Medications and Outcomes:
• On admission to the facility, his key medications included Sertraline 25 mg hs for mood disorder, Levothyroxine 0.050 mg qd for hypothyroidism, Namenda 10 mg qd for dementia, Prednisone 10 mg qd for COPD, Digoxin 0.125 mg qd for atrial fibrillation, and Tramadol 25 mg q8h PRN for pain.
• Namenda was subsequently increased some time after admission to b.i.d. Olanzapine 2.5 mg qd PRN was added for severe agitation. Melatonin 2 mg hs was added to help with sleep.
• On 4/1/12, Olanzapine 2.5 mg qd PRN was discontinued. There was no improvement noted.
• On 4/2/12, Sertraline was changed to every other day. No improvement was noted.
• On 4/19/12, Melatonin was increased from 2 to 3 mg hs. No improvement in his sleep was noted.
• On 4/23/12, Risperdal 0.25 mg was ordered for 3 days. A psychiatric consultation was requested.
• On 4/30/12, the psychiatrist recommended discontinuing Melatonin and Zoloft and starting Risperdal 0.25 mg qhs for possible dementia with mania. No improvement was noted.
• On 5/1/12, a Digoxin level was within the therapeutic range. Donald was restless and up much of the night.
• On 5/2/12, Trazodone 25 mg qhs was ordered with no improvement in sleep noted.
• On 5/7/12, staff noted an acute change in mental status and found Donald difficult to arouse.
Teaching: Part 1

Communicating with the Attending Physician about the Resident's Change in Condition

Have nurses review the background information for Donald Lee and then instruct them to respond to the questions below.¹

1. What information is least relevant to have in preparation for the call?
   a. Resident history of advanced dementia
   b. He has a history of COPD
   c. Increasing incidents of restlessness and problem behavior
   d. Recent history of dislodging his colostomy

2. When using the SBAR communication technique, the nurse’s initial statement to the physician should be?
   a. I’m sorry to bother you about the resident
   b. One of your residents seems to have a problem
   c. Resident has a history of dislodging his colostomy
   d. I’m concerned about Mr. Lee, he has an acute change in mental status and is difficult to arouse

3. In this situation, what patient data should be reported first?
   a. Details of the current mental status change
   b. Admission diagnoses
   c. Outcomes of medication changes
   d. Psychiatric consultation recommendations

4. Before discussing subsequent treatment or testing with the physician, the nurse should be prepared to
   a. Discuss potential causes of the acute change in mental status
   b. Review the resident’s story in chronological order
   c. Review the current medication regimen
   d. All of the above

Answers

1. B – The resident's COPD history is not immediately relevant to this situation. A list of diagnoses is not nearly as helpful as a clear and concise description of current mental status, including behavior, mood, and cognition.

2. D – The first part of the SBAR is to clearly and concisely describe the situation. Giving the resident’s name, a clear and meaningful statement of the clinical problem and the nurse’s concern, alerts the physician to the problem.

3. A – Since the change in mental status is the primary current issue, this information should be presented first and will then set the foundation for offering and evaluating additional pertinent information.

4. D – The nurse’s communication with the physician, regardless of clinical problem, should always give enough information so that the practitioner can begin to think about possible causes of the symptom or problem, in order to identify, to the extent possible, parameters for monitoring and the need for possible diagnostic testing, follow-up, and changes in treatment. It is important to

¹ Questions adapted from NURSE.com, Nursing Spectrum (DC/Maryland/Virginia), Clinical Vignette, June 18, 2012, page 31.
give the practitioner time to think through the situation in order to do more than just guess about what is going on or what to do next.

**Continuing Case of Donald Lee**
- **On 5/7/12,** Donald was transferred to the hospital Emergency Room. Lab and diagnostic tests that were done in the hospital were unremarkable. The resident was returned to the facility without hospitalization.
- **On 5/8/12,** Trazodone was discontinued and Namenda was reduced from b.i.d. to daily.
- **On 5/9/12,** Risperdal was discontinued.

**The Story – Part 2**

**How to Apply Critical Thinking/Reasoning to Determine Problem Cause:**

Every discipline can contribute to cause identification, by following an appropriate process. When done by a health care practitioner, cause identification is referred to as “diagnosis.” Nurses and those of other disciplines can help practitioners by providing enough of the right information to allow thoughtful diagnostic decision making. Every discipline, including nursing, can potentially apply the same thoughtful approaches to improve other cause identification activities.

Once the nurses/interdisciplinary team have completed the “Communicating with the Physician about the Resident’s Change in Condition” questions section, and have identified and discussed the correct answers, have the group focus on their **Critical Thinking/Reasoning** in trying to understand the cause of the resident’s issues. Critical Thinking/Reasoning can be accomplished by asking basic questions about the resident to distinguish between potential causes of the problem.

**Clinical Thinking/Reasoning Question for Donald Lee**

1. Could Mr. Lee have a medical cause of his behavior?
   - Could he be hypothyroid? He was taking a relatively low dose of thyroid replacement. His TSH on 9/19/11 was WNL (3.06). A repeat TSH on 3/23/12 was also WNL. Probability of hypothyroidism as a cause: **very low.**
   - Could he have an infection or heart failure? Chest X-ray 9/30/11 had shown small bilateral infiltrates and an L pleural effusion. In early 2/12, he had been hospitalized with pneumonia. However, there was no current clinical evidence of infections and lab tests were negative. Breathing and vital signs were unchanged. Probability of infectious or cardiac cause: **unlikely.**
   - Could Donald have delirium? The resident had a shortened attention span, frequent fluctuation in behavior and level of consciousness, increased level of involuntary motor activity (restlessness), and altered sleep cycle. All of these findings are consistent with delirium. Possibility of delirium: **high.**
   - Could Donald have some other contributing medical problem? He was not anemic. Despite his COPD, he was not hypoxic enough to account for these symptoms. Also, behavior issues fluctuated regardless of oxygen levels. Possibility of hypoxia: **unlikely.**

2. Could Mr. Lee have a medication cause for his behavior?
   - Could he have digoxin toxicity? Digoxin toxicity can cause various psychiatric symptoms. However, the serum digoxin level was in the middle of the therapeutic range. Probability of Digoxin toxicity: **very low.**
   - Could he have other medication-related adverse consequences? Prednisone can cause psychosis and other behavioral and mood changes. However, his dose was about equal to what the body produces
Normally, and the dose had remained constant for years. Probability of prednisone-related cause: very low.

- Could he have side effects from his psychopharmacological medications? Sertraline had been continued under the presumption that the resident had a diagnosis of depression. However, it was not clear why or when this was started. There was no clear evidence that he had a mood disorder. Any psychopharmacological medications, including antidepressants and antipsychotic medications, can potentially exacerbate behavior and psychiatric symptoms. In this case, they were not helping improve the symptoms. His behavior was getting worse. Possibility of adverse effects from existing medication regimen: likely.

3. Could Mr. Lee have a psychiatric basis for his behavior?

- Could Donald have psychosis? He could have psychosis, although the condition was fluctuating more than it was escalating steadily. Hallucinations, delusions, and paranoia were noticeably absent. Antipsychotic medications did not result in symptom improvement. Possibility of psychosis: low.
- Could he have a mood disorder? He was already receiving an antidepressant, despite lack of evidence for a mood disorder. His symptoms represented more than simple anxiety. Possibility of mood disorder: unlikely.
- Could he have a personality disorder? There was no evidence of a personality disorder during his earlier years, and the symptoms were not compatible with that. Possibility of personality disorder: unlikely.
- Could he have simple dementia-related symptoms? The determination of dementia-related symptoms is reached by first ruling out other possible causes. In this case, other likely causes were identified. Possibility that this was simply related to dementia: unlikely.

4. Could Mr. Lee have a psychosocial or environmental cause for his behavior?

- Could Mr. Lee have unmet personal needs causing his behavior? Between staff and family, his needs had been addressed consistently since admission. His worsening behavior was ongoing regardless of his personal needs being met. When asked about personal needs and comfort, Mr. Lee’s responses were not coherent or relevant. Possibility of unmet personal needs: unlikely.
- Could he have environmental causes? His environment had not changed since admission. Throughout his stay, multiple psychosocial interventions were implemented without success. Symptoms persisted and were not correlated with the presence or absence of such interventions. Nothing was working. Effort to redirect behavior failed. Possibility of environmental factors: unlikely.
- Was he indicating that he did not want the colostomy by trying to remove it? From the time of admission until his recent episodes started, he had never expressed or shown discomfort with the colostomy previously. It had never caused him any complications. The pulling on the colostomy was not an isolated activity, but was associated with increasing restlessness and uncontrolled motor activity. He seemed unaware about what he had done. Possibility of behavior relating to not wanting his colostomy: unlikely.

Outcome of Critical Thinking/Reasoning

Based on the above critical thinking questions, the answers indicating Yes/Likely help narrow down the thinking about likely causes of the behavior. These outcomes include:

- Primary: He has delirium and side effects from psychopharmacological medications
- Secondary: He has a baseline of chronic, dementia-related behavior

The reporting nurse gives the practitioner enough information to engage in a meaningful conversation about these potential causes. Before and after the specific incident that is reported, the entire staff works with the
The practitioner to identify next steps (medication changes, monitoring, etc.) to test these hypotheses about causes.

The Subsequent Story of Donald Lee

After stopping his Sertraline and Trazodone and reducing the Namenda dose, there was a remarkable and rapid improvement. Donald became calmer, stopped pulling on his colostomy, slept much better at night, was easily directable, sat out in the hallway with his family, attended some activities, and was generally pleasant and responsive. He has remained stable for several months. However, he was just as confused and disoriented as before.

Teaching: Section 2

How to Apply Critical Thinking/Reasoning to Determine Problem Cause:

- When teaching a group of caregivers, consider using a Learning-Circle* approach. Ask clinicians to frame a question (Could the resident have …) and repeat the exercise until all possible questions are identified. Keep a list of the questions.
- Once all the questions are put forth, consolidate them by eliminating redundancies. It will be helpful to categorize question based on possible Medical Causes, Medication Causes, Psychiatric Causes, and Psychosocial/Environmental Causes.
- Discuss the answers to the questions and ask clinicians to identify and help staff understand the reasoning behind answers to the various possibilities, including Yes/Likely, Unlikely/No, and Probability High, Probability Low
- From the critical thinking exercise, have clinicians develop the key clinical assumption(s) and develop a SBAR in preparation for reporting to the physician on this case.
- Have clinicians use this approach in reporting to the physician in other cases (not just behavior or psychiatric issues).

*Learning Circle Resources
http://www.pioneernetwork.net/Data/Documents/LearningCircleKeane.PDF

http://www.iearn.org/circles/lcguide/ A teachers’ guide to cross-classroom collaboration on projects integrated with curriculum.
AHCA’S SUGGESTED TOOLS FOR REDUCING OFF-LABEL USE OF ANTIPSYCHOTICS:
How These Tools Can Improve Regulatory Compliance

AHCA suggests a number of tools that can be used in a facility to assist in the reduction of off-label use of antipsychotics. To help achieve compliance with some regulatory requirements that relate to the off-label use and reduction of antipsychotics, the ideal is to use all of these tools or tools with similar components. By using them effectively, a facility may not only reduce the off-label use of antipsychotics but may also receive improved regulatory compliance related to their use.

“Clinical Guideline: Managing Behaviors Expressed by Residents with Dementia” directs the nurse to assess and evaluate a resident using the SBAR algorithm. The review must include, at a minimum, seven specified areas. Communication with professionals as well as with the patient and the patient’s family are important elements of this Guideline.

The SBAR is a communication tool that assists a nurse effectively convey to a physician the assessment process that has been used to reach certain conclusions and recommendations. This tool may be used when a patient has experienced a significant change and when the nurse would like to discuss a different approach for the care or a patient.

Antipsychotic Medication Tapering Checklist provides a systematic way to determine the likely success of tapering an antipsychotic. When completed and added to a patient’s medical record, this provides strong support for the decisions made related to each patient and implementing a tapering regimen.

Both the Antipsychotic Medications QA Review Tool and the Assessment of Psychotropic Medications will provide necessary information and guide discussion and decision-making related to the use of psychotropic medications for individual patients. This can be done within or independent of the QA&A process.

Taken in total, these tools will assist a facility to be in compliance with the following F-Tags:

F157 – Notification of Changes
F154, F155 – Notice of Rights and Services
F272, F273, F274, F275, F276, F278 – All related to assessments, reassessments, or coordination of assessments
F279 – Comprehensive Assessments
F281 – Professional Standards of Care
F309 – Pain Management
F329 – Unnecessary Medications
F281 – Professional Standards
F428 – Medication Regimen Review
F520 – Quality Assessment and Assurance
Questions to Consider in Interdisciplinary Team Review of Individual Dementia Care Cases

- If the behavioral symptoms represent a change or worsening, was a medical work up performed to rule out underlying medical or physical causes of the behaviors, if appropriate?

- Were current medications considered as potential causes of the behaviors (i.e., those with significant anticholinergic or other side effects)?

- If a medical cause (e.g., UTI) was identified, was treatment (if indicated) initiated in a timely manner?

- If medical causes were ruled out, did the staff attempt to establish the root causes of the behaviors, using a careful and systematic process and individualized knowledge about the resident when possible? Were family caregivers or others who knew the resident prior to his/her dementia consulted about prior life patterns, responses to stress, etc.?

- Was the initial clinical indication for the medication valid?

- Were non-pharmacologic, person-centered interventions tried before medications (other than in an emergency)? Were the results documented?

- Were specific target behaviors identified and desired outcomes related to those behaviors documented? Were caregivers aware of the target behaviors and desired results of the medication?

- Was the resident or appropriate legal representative consulted about the decision to use an antipsychotic medication and was that discussion documented?

- If a drug is continued for more than a few weeks, is the original clinical indication still valid (are the behaviors still present)?

- Is appropriate monitoring in place and is the team aware of the potential side effects?

- If new symptoms or changes in condition occurred after an antipsychotic medication was started, was medication use considered as a potential cause of a change or symptom?

- If on a medication, did the pharmacist perform a medication regimen review and identify related signs and symptoms, or did the staff inform the pharmacist if symptoms occurred after the last pharmacist visit?
Suggested Provider Checklist for Improving Dementia Care

% of residents in facility on atypical antipsychotics: ____ Quality Measure State Percentile Rank – antipsychotics: ____

YES | NO

Staff in all departments, are trained in person-centered care and how to respond effectively to behaviors (access sample training programs on Advancing Excellence website; Hand in Hand).

In addition to medical and psychiatric history, recent changes in behavior or cognition and other standard clinical evaluations, at admission information is obtained from the resident, family, and/or caregivers on the resident’s preferences, routines, pre-dementia personality, social patterns, responses to stress and effective interventions.

The information obtained on during the admission process is conveyed to direct caregivers.

This admission information is integrated into the care plan and may be revised over time as the resident’s condition and needs change.

Interviews with staff demonstrate that they have implemented and are following the care plan, continue to seek input from family members or care givers for unresolved issues, and communicate with practitioners regarding change in condition or new or persistent symptoms.

If a resident is placed on an antipsychotic medication, there is documentation in the record that the resident or appropriate legal representative was involved in the decision.

Facility has consistent staff assignments (same Certified Nursing Assistant to same resident 5 days/week).

Certified Nursing Assistant to Resident Ratio 1st shift/2nd shift/3rd shift

Senior leadership (Nursing Home Administrator, Director of Nursing, Medical Director) attend care plan meetings periodically for residents with unresolved behavioral or psychological symptoms of dementia.

Interdisciplinary team seeks input at care plan meetings from the Medical Director, Consultant Pharmacist and Certified Nursing Assistants for residents with behavioral or psychological symptoms.

Providers conduct outreach and education to the resident’s family and strongly encourage their participation in care plan meetings (offering to flex the schedule or use conference calls when the family cannot physically be in attendance).

Nursing Home Administrators and Directors of Nursing review quality measures (e.g., monthly) and use the Quality Measures report to identify residents who may need alternative interventions and oversee their implementation.

Each month, Nursing Home Administrators and Directors of Nursing review Quality Measures report, along with the Pharmacy Consultant report, to identify residents appropriate for possible reduction/elimination of antipsychotics. The review of aggregate data should be combined with real-time, case-based information and input from practitioners.

Nursing Home Administrators and Directors of Nursing review Pharmacy Consultant’s report quarterly with Consultant Pharmacist and Medical Director to track and trend data.

Direct caregivers (Certified Nursing Assistants), together with the family and care plan team, is involved in the process of developing and implementing effective, person-specific interventions to address behavioral symptoms.

If any resident is admitted on an antipsychotic or is started on an antipsychotic after admission, the Consultant Pharmacist, along with the practitioner, reviews that resident’s care plan, including all medications, within 24-48 hours.

A documented process is in place and is utilized when initiating an antipsychotic prescription (e.g., standard order set, decision support algorithm, routine monitoring recommendations, etc.).

“Yes” answers require supporting documentation and visual confirmation by quality improvement personnel.

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# Table 1
## Review of Non-pharmacologic Approaches for Treating Behavioral and Psychological Symptoms of Dementia

<table>
<thead>
<tr>
<th>Type of Non-Pharmacologic Approach</th>
<th>Description/ Specific Approaches</th>
<th>Efficacy for Reducing Behavioral and Psychological Symptoms of Dementia</th>
</tr>
</thead>
</table>
| **Sensory Stimulation Approaches** | Sensory stimulation approaches focus on stimulating the senses of the person with dementia. The aim of these approaches is to respond to the unmet needs for stimulation, to enhance the senses and to achieve therapeutic effects such as pain control, relaxation and reduction of anxiety. Some sensory stimulation approaches are informed by physiological models regarding the calming influence of sensory touch or proximity associated with some techniques such as massage. Examples include: | - Music therapy has demonstrated efficacy in reducing agitation (albeit for short periods of time) among persons with dementia, although overall study findings have been inconsistent. Various types of music therapy have been rigorously tested including gentle songs and individualized music therapy.  
  - MSS combines light, music, tactile, and aroma therapies. Findings regarding the effect of MSS on behavioral symptoms are inconsistent but some preliminary randomized trials have demonstrated improved short term BPSD outcomes when using Snoezelen as well as other positive experiences associated with the treatment, meriting further testing.  
  - Several RCTs testing TENs have demonstrated no effect on BPSD. There is no evidence to support the use of TENs to treat behavioral symptoms.  
  - Insufficient evidence exists to recommend the use of white noise in treating behavioral symptoms.  
  - Massage and touch therapy has demonstrated a moderate effect on BPSD, specifically agitation.  
  - Aromatherapy has demonstrated moderate efficacy in reducing agitation, however more rigorous research is needed. |
| **Behavior Management Approaches** | Behavior management approaches are intended to support adaptive behavior of people with dementia through reinforcing certain kinds of social behavior and reducing behavioral symptoms through, for example, ignoring the behavior. Examples include: | Inconsistent study results and limited methodological rigor provide insufficient evidence to support the use of behavioral management techniques at this time.11,15 |
| **Cognitive/Emotion-Oriented Approaches** | Cognitive/Emotion-Oriented Approaches focus on eliciting positive emotional behavioral responses. Examples include: | Currently, evidence does not support the use of any of these approaches for BPSD. There is limited and inconsistent evidence regarding the use of cognitive/emotion-oriented interventions. Some of these interventions, such as simulated presence therapy (SPT) and reality orientation may actually have an adverse effect in some persons with dementia and are not recommended for treatment of BPSD. |
| **Structured Activity Approaches** | Structured activity approaches may include recreational activities as well as certain forms of exercise on a regular basis. The goals of structured activity approaches are often to develop and/or stimulate the social, cognitive and physical abilities of persons with dementia and to reduce boredom. Examples include: | - There is insufficient evidence to conclude the effects of exercise interventions or structured activities on BPSD; this is largely due to methodological limitations of existing studies.12,16  
  - There is also limited evidence regarding the effect of exercise on BPSD, however, other benefits of exercise programs such as improved sleep may merit their use depending on individual care needs.15 |
Social Contact Approaches (with real or simulated stimuli)

Real or simulated social contact approaches may include face-to-face interaction, group activities or audiostapes from family members. Social interactions are believed to produce positive mood/affect and to subsequently reduce BPSD. As nursing home residents also experience boredom and social isolation, social interaction is believed to generally improve the well-being of people with dementia. Examples include:

- Animal-assisted therapy
- One-on-one interaction
- Simulated presence therapy (i.e. simulated family presence)

While Animal-assisted therapy (AAT) has demonstrated preliminary positive findings, the current evidence base is very limited and includes primarily non-randomized, very small scale studies. Additional research is needed to understand whether AAT effectively reduces BPSD.

- There is currently an insufficient evidence base to support the efficacy of one-on-one interaction for reducing BPSD, however further testing of this approach is merited because preliminary work suggests that people with dementia benefit by being engaged in social contact.

- There is currently inadequate evidence to recommend the use of simulated-presence therapy and it may have an adverse effect in some individuals.

Environmental Modification Approaches

Environmental modification approaches focus on matching the environment to the needs of the person with dementia. This can be done in different ways by providing conditions that help to maintain the person’s autonomy and independence, create a home-like atmosphere and thereby reduce the level of stress. The approaches are often designed specifically to reduce wandering behaviors, or mood/sleep disturbances. Examples include:

- Wandering areas
- Natural/enhanced environments
- Reduced stimulation units

Environmental modification interventions have not demonstrated efficacy in reducing BPSD.

Clinically-Oriented Approaches

Clinically-oriented approaches are generally (but not always) multi-faceted and aim to guide providers in relieving the underlying unmet needs or causes contributing to BPSD. The intended outcomes include reducing the use of psychotropic drugs and BPSD, along with improving other health outcomes. Examples include:

- Pain management
- Comprehensive assessment
- Restraint removal
- Decision-support approaches
- Delirium recognition and management

Most of these interventions have demonstrated positive (not necessarily significant) effects in reducing BPSD but few have been tested in rigorous trials and as a result are not included in many systematic reviews.

- A systematic approach to pain management has been shown to significantly reduce agitation in nursing home residents with moderate to severe dementia.

- Individualized interventions that utilize a systematic algorithm to support clinical-decision making demonstrate strong potential for treating and managing BPSD and unmet needs of persons with dementia. Since these approaches are particularly promising, more information is provided later in this document.

Staff-training Approaches (See also Education and Leadership Development section of Toolkit)

Caregiver development as an approach is intended to increase the knowledge of staff who are called upon to respond to BPSD. The aim of this type of approach is to reduce behavioral symptoms and the stress caregivers experience themselves. Most staff training approaches are educational or psychosocial and teach:

- Communication skills
- Person-centered bathing or towel bathing
- Minimizing care-resistant behaviors during oral hygiene
- Strategies for responding to needs of persons with dementia
- Understanding and responding to BPSD

Generally, findings from staff-training approaches demonstrate limited sustained improvement in BPSD and suggest that continual training or reinforcement are needed to influence behavior change. These studies have produced inconsistent findings for the strategies used and are difficult to evaluate due to methodological limitations, as such insufficient evidence exists at this time to support the efficacy of most staff-training approaches for reducing BPSD. Some specific approaches merit replication in a more rigorous manner.

Person-centered Care Approaches

The concept of person-centered care is to train care providers to focus on the person during the task rather than the task itself. This training may also emphasize abilities-focused care and maximizing comfort. An example of a person-centered care approach to reduce agitation includes:

- Person-centered bathing or towel bathing

Use of person-centered bathing and towel bathing has demonstrated reduced agitation and aggression during bathing experiences.
Table 2
Efficacious and Feasible Non-pharmacological Approaches for Behavioral and Psychological Symptoms of Dementia

<table>
<thead>
<tr>
<th>High Feasibility</th>
<th>Approach</th>
<th>Evidence-based Summary</th>
<th>Considerations for Feasibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music Therapy</td>
<td>• Music therapy approaches can range from formal activities with a music therapist to listening to recordings on an iPod or in a small group setting. • Individualized music that is calm and at 55-60 beats per minute, which mimics human heartbeat, has shown to be the most effective in alleviating agitation. In selecting proper music, match the ticking of the clock to the beat of the music.</td>
<td>Several RCTs have reported reduce agitation, wandering and aggression while residents are listening to music. • The effects of music therapy are brief, and may dissipate quickly afterwards.</td>
<td></td>
</tr>
<tr>
<td>Massage/Touch Therapy</td>
<td>Hand massage with calming music has been shown to decrease agitation. Touch combined with verbal encouragement during mealtimes improved intake</td>
<td>The greatest limitation to massage/ touch therapy is limited staff time to engage in this activity. • Staff may also need additional training and/or incentives to initiate massage/touch therapy.</td>
<td></td>
</tr>
<tr>
<td>Pain Management</td>
<td>A systematic approach to pain management has been shown to significantly reduce agitation in nursing home residents with moderate to severe dementia.</td>
<td>Improving pain management is both highly feasibly as well as a basic clinical standard of practice. • <a href="http://www.geriatricpain.org">www.geriatricpain.org</a> provides free resources to nursing home providers, including copies of tools for pain assessment and methods for pain management.</td>
<td></td>
</tr>
<tr>
<td>Moderate Feasibility</td>
<td>Serial trial Intervention (STI)</td>
<td>The STI has been shown to reduce discomfort and reduce behavioral symptoms among nursing home residents.</td>
<td>Implementation of the STI requires investment from facility staff including leadership to support adoption of protocols. • It also requires specialized training of nurses to carry out the intervention, which may not be feasible in all NHs.</td>
</tr>
<tr>
<td>Aromatherapy</td>
<td>• Most studies that demonstrated positive outcomes included massage with administration of calming essential oils, such as lavender. • Some study results suggested that aromatherapy had adverse effects in a small number of patients.</td>
<td>Aromatherapy should be discussed with a qualified aroma therapist who can advise on contraindications. • To ensure minimal harm, staff will need to assess whether aromatherapy is likely to be well received by first assessing tolerance of essential oils to be used (including allergies). • Treatment times in different approaches varied, so providers likely need to establish their own treatment protocols.</td>
<td></td>
</tr>
<tr>
<td>Treatment Routes for Exploring Agitation (TREA)</td>
<td>TREA has been shown to significantly reduce agitation among nursing home residents with dementia.</td>
<td>The TREA approach also requires substantial investment from a care system in order for the protocols to be realized. • A large component of the TREA protocol includes information gathering by staff which may be time consuming and resource-intensive. • Unmet needs were hypothesized based on various data sources that may not be readily available to all nursing homes including physician assessments and observations of behavioral disturbances.</td>
<td></td>
</tr>
</tbody>
</table>


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## Screening Admissions for Antipsychotic Use - Step By Step Method

**Instructions:** Please complete this detailed checklist based on residents admitted on antipsychotics as identified in your data.

When the referring facility sends the Level 1 Screen for potential admission, you have the right to ask questions. If they are on an antipsychotic medication, consider asking these questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>How long has the person been on antipsychotics?</td>
<td></td>
</tr>
<tr>
<td>Why is the person on the antipsychotic?</td>
<td></td>
</tr>
<tr>
<td>Why was this person admitted to the hospital?</td>
<td></td>
</tr>
<tr>
<td>Did the person have problems that predispose them to delirium?</td>
<td>INFECTIONS</td>
</tr>
<tr>
<td>When the person was admitted to the hospital, where were they admitted from?</td>
<td>HOME</td>
</tr>
<tr>
<td>HOME WITH HOME HEALTH</td>
<td>PERSONAL CARE HOME</td>
</tr>
<tr>
<td>If the person was admitted from home, did they live alone?</td>
<td>YES</td>
</tr>
<tr>
<td>What was this person’s prior level of function or functional status?</td>
<td>STATUS PRIOR TO ADMISSION:</td>
</tr>
<tr>
<td>Does the person have a psychiatric diagnosis?</td>
<td>YES</td>
</tr>
<tr>
<td>If yes, what is the diagnosis?</td>
<td></td>
</tr>
<tr>
<td>If yes, how long ago was the person diagnosed?</td>
<td></td>
</tr>
<tr>
<td>Should a level 2 screening be performed?</td>
<td>YES</td>
</tr>
<tr>
<td>Was a psych consult completed during this hospital admission?</td>
<td>YES</td>
</tr>
</tbody>
</table>

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Reducing Antipsychotics in Your Facility - Step By Step Method

Instructions: Please complete this detailed checklist based on residents currently on antipsychotics as identified in your data.

Does your staff meet regularly to discuss antipsychotic use?  
☑ NO  ☐ YES (IF YES, WHAT DAY OF THE WEEK)

What meeting is utilized as a venue for discussion of antipsychotic use?  
☐ RISK MGMT.  ☐ INTERDISCIPLINARY STAFF MTG  ☐ QAA  ☐ OTHER – PLEASE NOTE

Are the following staff included on your team?  
☐ PSYCHIATRIC MGMT CLINICIAN  Cox Psychiatrist/NP or attending physician (if Psych Mgmt Clinician not available)  ☐ CLINICAL PHARMACIST  ☐ DON  ☐ CNA REPRESENTATION - to describe recent behavioral issues  ☐ UNIT DIRECTORS  ☐ OTHER:

Have you obtained a list of all residents currently on antipsychotics?  
☑ YES  ☐ NO (If no, please complete this step)

Have you identified the name & dose of antipsychotic for each resident?  
☑ YES  ☐ NO (If no, please complete this step)

Did you utilize dosing information from the chart?  
☑ YES  ☐ NO (If no, please complete this step)

Have you identified all residents on prn antipsychotics?  
☑ YES  ☐ NO (If no, please complete this step)

Have you identified when the antipsychotic order was written for each resident?  
☑ YES  ☐ NO (If no, please complete this step)

Have you identified the antipsychotic use for each resident? Be sure to look for weak reasons like sleep, wandering, anxiety.  
☑ YES  ☐ NO (If no, please complete this step)

Have you reviewed the chart to look for past diagnosis?  
☑ YES  ☐ NO (If no, please complete this step)

Have you removed residents with exempted diagnoses from consideration? (i.e. Schizophrenia, Huntington’s, Tourette’s syndrome)  
☐ YES  ☐ NO (If no, please complete this step)

Have you reviewed the chart to look for obscure diagnoses? (e.g. ‘organic hallucinosis’)  
☑ YES  ☐ NO (If no, please complete this step)

If residents were delirious on admission, then, did you attempt dose reductions in 1-3 months?  
☑ YES  ☐ NO (If no, please complete this step)

Have you attempted to establish a psychiatric diagnosis if appropriate?  
☐ YES  ☐ NO (If no, please complete this step)  
- Delete redundant diagnoses - it’s tough to be bipolar and schizoaffective  
- This may require psychiatric (re)assessment

Have you considered eliminating all PRN antipsychotic medications first? This should be based on use and dose.  
☑ YES  ☐ NO (If no, please complete this step)

Have you focused on residents with very low (24 hr) dose antipsychotics? (see dosages below)  
☑ YES  ☐ NO (If no, please complete this step)

<table>
<thead>
<tr>
<th>MEDICATION (Generic and Brand)</th>
<th>INITIAL DOSE DISCONTINUATION</th>
<th>SECOND DOSE DISCONTINUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone/Risperdal</td>
<td>0.25 mg or less</td>
<td>0.5 mg</td>
</tr>
<tr>
<td>Olanzapine/Zyprexa</td>
<td>2.5 mg or less</td>
<td>5 mg</td>
</tr>
<tr>
<td>Quetiapine/Seroquel</td>
<td>25 mg or less</td>
<td>50 mg</td>
</tr>
<tr>
<td>Ziprasidone/Geodon</td>
<td>20 mg or less</td>
<td>20 mg BID</td>
</tr>
<tr>
<td>Aripiprazole/Abilify</td>
<td>5 mg</td>
<td>7.5 mg or less</td>
</tr>
</tbody>
</table>

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